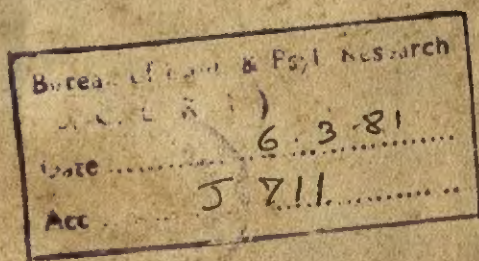


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MENTAL HYGIENE

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KATHLEEN JONES, Ph.D.

Community and mental health

When the history of the world mental health movement comes to be written—and there is a task here worthy of a new Toynbee or a future Max Weber—one of the fundamental themes must be the development of the concept of the community care.

By a long process of evolution and a few imaginative leaps in the dark, we have progressed from a belief in a limited and somewhat monolithic mental hospital service to a vision of a flexible and diversified service which will represent society's changing response to the changing needs of psychiatric patients. Stereotyped habits of thought have been replaced by fresh, empirical thinking about clinical care, about administrative methods, and about the basic philosophy which underlies both.

In this field, the Dutch are the acknowledged pioneers, and it is particularly fitting that we should be discussing this subject in Amsterdam, where Professor Querido's work and that of his colleagues has been an

inspiration to psychiatrists and administrators from so many countries. Perhaps the most impressive characteristic of this work has been the humility of approach, their insistence on starting from an actual situation and investigating it in depth by means of a variety of research techniques.

Professor Querido's recent book *The Efficiency of Medical Care*¹ illustrates this view, by its careful and scholarly refusal to theorize about the situation until detailed investigations have shown its nature and characteristics. I should like to proceed with similar caution, by first outlining the present situation in Britain, and then by discussing some of its problems and potentialities.

Dr. Jones is senior lecturer in social administration, University of Manchester, Manchester, England.

This paper was presented at the sixteenth annual meeting of the World Federation for Mental Health, held in Amsterdam, Netherlands, in July, 1963.

¹ Querido, A., *The Efficiency of Medical Care* (Leiden, Netherlands: H. V. Kroeser, 1963).

Some of our problems will be relevant to those of other countries, and some may be international problems in the true sense, that is, problems common to all countries; but, in the present state of our knowledge, it would probably be unwise to try to distinguish these in any detail.

In Britain, the view that the institution was the right place for the mentally disordered, both for their own protection and for that of society, was dominant right through the nineteenth century. Mental hospitals were constructed in three great waves of building development, following the County Asylums Act of 1808, the Lunatics Act of 1845, and the Lunacy Act of 1890. They were usually located several miles from the town which formed their main catchment area, partly because rural land was cheaper than town land, and partly because there was a rejection mechanism at work—the patients being literally as well as metaphorically rejected by the society from which they came.

Until 1913, the law made no clear distinction between the mentally ill and the subnormal; but when a separate service was instituted for subnormal patients, a new principle emerged. Hospitals, or “colonies” as they were then called, were to care for the low-grade patients and for those whose home backgrounds had been found unsuitable; but there were provisions for the care and supervision of patients who remained in their own homes. The care of the mentally ill and that of the subnormal were administratively separated, and there was nothing equivalent to this system for the mentally ill.

In the nineteen twenties, however, outpatient clinics began to develop. This was a major breakthrough, the first means of treating patients without committing them

to the mental hospital under certification. In 1930, mental hospitals were empowered to take voluntary patients. The huge chronic populations remained, but a new category of short-stay patients appeared, and the question of aftercare became an urgent one. Hospitals began to appoint social workers, and the nucleus of a hospital-based psychiatric service developed.

After World War II, the institution of the “Welfare State” brought radical changes. A variety of locally-based services for the care of underprivileged or handicapped groups in the community developed in the hands of the county or county borough authorities. Each of these local authorities set up a Mental Health Department as a subsection of the Public Health Department.

Inevitably, the development of this new service was uneven. Some local authorities were quick to grasp the implications of their new position, and they began to experiment with community services. Others did very little, apart from their statutory duties—the supervision of subnormals in the community and the conveyance of the mentally ill to the mental hospital. In a few cases (Worthing is probably the best-known) the hospital took the initiative in providing a community service; but the relation between the role of the local authority and that of the hospital was obscure and quite often the work went by default with neither taking the initiative.

The Mental Health Act of 1959 changed the situation decisively. This act was the result of a Royal Commission which saw a great and expanding future for community care and a dwindling role for the hospital. Even while its discussions were taking place, there were new developments: the day hospital movement began to spread; mental hospitals, realizing the dangers of “institutional neurosis” so ably described by Dr. Russell Barton² began to experi-

² Barton, W. Russell, *Institutional Neurosis* (Bristol, England: John Wright & Sons, 1959).

ment with the idea of the "therapeutic community" and to open their doors; and local authorities began to test out the potentialities of hostels for those who had no settled homes, and sheltered workshops for those who could not be fully absorbed into industry.

By 1959, the idea of a diversified system of care was widely accepted, although the place of the inpatient hospital was and still is the subject of much debate. The official policy of the Ministry of Health since 1961 has been based on a statistical projection from trends in the years 1954-59³ which suggested a possible reduction in inpatient beds from 3.3 to 1.8 per 1,000 population within 15 years. This policy has been criticized on the following grounds:

- (a) That a long-term projection cannot be adequately based on a short-term trend;
- (b) That the decline in mental hospital populations between 1954 and 1959 was marginal, and is unlikely to continue indefinitely of its own momentum;
- (c) That this decline resulted from a change in administrative policy rather than from clinical advance;
- (d) That there is a need for local variation in provision according to local need;
- (e) That any decision about the future of the mental hospital population is premature until the potentialities and limitations of community care have been more thoroughly explored.^{4, 5}

In recent months, the argument concerning "institutional or community care" has widened to include other forms of provision—e.g., homes for old people and epileptic colonies, and two main points of view have emerged. One is that the institution is a relic of custodialism, necessary enough when other services were not available, but now outmoded. The second view is that although the institution is now only one

among a number of means of social care, it still possesses a useful function for people whose disabilities are so great that they need a sheltered environment.

The argument is very largely one of degree, for very few people are prepared to push either view to its logical extremes by contending that all institutions should be abolished, or that all patients now in institutions should stay there. The question is how many can be rehabilitated by modern methods of care, and under what circumstances.

A preliminary and necessary step is to ascertain what kinds of patients are now in the institutions under review, and to assess how far they would be capable of rehabilitation under existing conditions of community care. As Professor Querido has shown, such arguments need to be tied to what is possible and practicable now if they are to retain any contact with reality.

With these considerations in mind, a patient census of 10,000 psychiatric beds in the Leeds region has been mounted as a result of co-operation between the Regional Hospital Board and the University of Manchester. We hope that the first results of our analysis will be available early next year.

This controversy concerning "institutional or community care" may be a peculiarly British one; but the basic question underlying it is one of *balance* between the different parts of a diversified service. It seems likely that other countries will have encountered this question, although possibly framed in different terms, according to

³ Tooth, G. C. and E. M. Brooke, "Trends in the Mental Hospital Population and Their Effect on Future Planning," *Lancet* (April 1, 1961).

⁴ *Psychiatric Services in 1975. Political and Economic Planning* (London: Queen's Gate, 1963).

⁵ Jones, K. and R. Sidebotham, *Mental Hospitals at Work* (London: Routledge and Kegan Paul, 1962).

local tradition and needs. It is allied to two other questions—those of dimension and finance.

The problem of *dimension* arises from the fact that psychiatric need is difficult to estimate or delimit. Epidemiological work is an urgent necessity; but while there is little argument about the extent of the field in other areas of epidemiology (we can establish clearly who suffers from typhus or smallpox), the need for psychiatric care must always be based on a multiple assessment. It is a matter not simply of disease or handicap, but of disease or handicap *plus* social factors—no home, a poor home background, relatives who cannot cope with the patient, inability to hold down a job, and so on.

British experience is that increased provision has always resulted in increased demand. In the early days of outpatient clinics, it was thought that they would reduce the need for inpatient beds, but in fact they provided a supplementary service rather than an alternative service. Day hospitals have also tended to draw more people into the orbit of the Mental Health Services, rather than providing a new means of catering for those already under care. The size of the problem is conditioned by the services we are prepared to offer. Presumably there is a limit to this process somewhere, but it is doubtful whether any country has yet made sufficient psychiatric provision to reach it. As Professor Sivadon said recently, where mental health is concerned, all countries are "developing" countries.⁶

There is thus no clear answer to the problems of dimension. If one asks, "How good a Mental Health Service must we provide?" the answer must be "The best one we can afford."

The question of *finance* is basically one of allocating scarce resources among apparently bottomless needs. It seems to be a fundamental law of any society that the allocation will favor those who serve society best. Thus, primitive societies have been known to abandon the old or expose the sick in time of famine or attack, concentrating food supplies on the working, fighting population (who guarantee the present survival of the group) and the children (who guarantee its future survival). It seems likely that this law holds good in more complex societies also. It is much easier to get money and equipment for a social service which will restore workers to their productive employment, or which will benefit children, than to obtain these things for the mentally ill, the subnormal or the old.

It seems likely that those who administer the Mental Health Services will always have difficulty in securing the share of the national resources which social justice demands. The proper care of psychiatric patients costs a good deal of money, and it is difficult to demonstrate an adequate return on investments. A proportion of mental health work is, and perhaps always must be, economically unproductive.

Much of the opposition to adequate financing is not rationally expressed. If it were, it would be easier to combat; but it takes the form of agreeing that provision is necessary some time, and then putting it off indefinitely; or claiming that it will be sufficient to enlarge an existing building when the real need is for another building elsewhere; or expecting one psychiatrist "temporarily" to do the work of two, or one nurse or social worker to do the work of four; or arguing that it is "good for the patient" to receive only minimal care, when the real benefit is to the taxpayer.

There are, of course, times when financial saving and therapeutic advantage do

⁶ Sivadon, P., in an address presented at the Annual Conference of the International Hospital Federation, held in Paris in June, 1963.

genuinely go hand in hand, when an authority can save money and at the same time produce a better service; but the occasions when this is possible are probably rarer than we care to think. An expensive service is no guarantee of quality, because the money can be spent unwisely, but a cheap service is rarely anything but an indication of inferior standards.

It is often claimed that day hospitals and other community care agencies can provide a cheaper service than that of the mental hospital. This may be so, but there is an urgent need for a full-scale costing study to prove it. The claims which are made for day hospitals sometimes ignore four important points:

(a) The difference between capital and maintenance cost. A day hospital is cheaper to build, but might be more expensive to maintain if it required a higher staff ratio.

(b) The difference between marginal cost and average cost. Calculations are sometimes based on the additional cost of the day unit to the cost of a parent inpatient unit. This is marginal costing. To give a reasonable figure, the cost of facilities used jointly by the day hospital and the inpatient hospital should be split between them.

(c) Transferred cost. Day hospitals may be dependent on services paid for by some other authority; e.g. in England, ambulance and social work services, which are paid for by the local authority. These costs should be included.

(d) Submerged cost. Day hospital care might result in a longer average stay than inpatient care, or a higher relapse rate.

Psychiatrists sometimes feel impatient at the mention of cost and financing, arguing that cost does not matter as long as the patient gets the best possible service. I think this is unrealistic. Just because it is difficult to get a fair share of the community's resources for psychiatric patients, it is im-

portant that psychiatrists should give consideration to these issues, and should put their claims in terms which politicians and government servants can understand.

For instance, a study of mental hospital costs in the north of England⁷ showed that, of three hospitals studied, the one with the highest weekly cost and the most intensive medical care actually had the lowest cost per case, because patients were discharged more quickly and did not release more often. Good care may be cheaper than minimal care in the long run. I think facts of this kind are worth demonstrating. Certainly studies in efficiency, whether linked to cost or organized on some other basis, may be crucial to development.

A further problem raised by the advent of community care is that of *selection of service*. When the traditional mental hospital was the only means of treatment, the question was simply whether the patient should enter hospital or stay at home. When there is a diversified service, a day hospital, an outpatient clinic, a half-way house, an inpatient ward all offer different types of care at different levels of intensity, appropriate for different needs. Each has a distinct function, and they are not necessarily interchangeable. From a whole range of services, the doctor must choose the one appropriate to his patient's needs.

This involves a skilled assessment, based on two kinds of knowledge—knowledge of the patient's condition and his environment, and knowledge of the varied resources of the community, so that needs and resources can be matched. The kind of administrative knowledge necessary for an assessment of resources has rarely been included in medical curricula, but several British universities are now including some teaching (whether described as social ad-

⁷ Jones and Sidebotham, *op. cit.*

ministration or social psychiatry) for medical students or postgraduate students in psychiatry.

Where some of the newer agencies for community care are concerned, the question of *function* is still being debated. Five years ago, we were arguing about the function of the day hospital. Did it provide the first stage in aftercare for those who had had inpatient treatment? Did it provide alternative care—a means of reducing the inpatient population? Did it provide supplementary care, drawing on a new and hitherto untreated population? The answer seems to lie somewhere between the three, but there are still many local differences. We may use the same term "day hospital" for agencies serving different and even mutually exclusive purposes.

Since the Mental Health Act envisaged the development of hostel facilities, there has been a corresponding debate on the function of the hostel. Should it be of the half-way house type for patients in the process of rehabilitation? Should it provide a home for the chronic patient with no family who no longer needs the full resources of the mental hospital? Should it provide for patients who can go out to work full-time or those who cannot work at all? Should it mix patients with different needs, and if so, in what proportions?

Doubtless some large authorities will be able to provide specialized hostels for different types of patients, but for the smaller towns and the rural areas, the solution is not so easy. Some appear to be constructing hostels because this is official policy, with no clear idea of what patients they would like to take—but a strong suspicion that, whatever their preferences, they will eventually have to deal with unemployable, elderly and chronic patients.

This would be very undesirable. Hostel accommodation for patients who stay only a

few weeks, or who are out all day, may be quite satisfactory; but as yet we have few trained hostel staffs, and hostels cannot provide all the facilities for socialization which a mental hospital has—the workshops, the sports fields, the cinemas and entertainments, the libraries, the education classes. Such facilities could not be provided economically for 10 or 20 patients.

Perhaps we should think seriously about defining "community care," because it is evident that the phrase is being used in many different ways. In fact, it is seldom defined at all. It is usually denoted: "Community care means day hospitals, night hospitals, outpatient clinics, day hospitals and so on." It is much more difficult to describe its attributes.

It is, of course, possible to define "community care" negatively by saying that it means any kind of care apart from that provided by the institution—the mental hospital—but this may be a false dichotomy. A good mental hospital is part of the community, anxious to keep its patients in touch with community life and to be "a flowing stream rather than a stagnant lake." It is no longer, in most cases, what it was in the nineteenth century—an isolated, forbidding institution for society's rejects.

I suggest the following attributes as being essential to a reasonable standard of community care:

1. *Diversity.* There must be several different types of care.
2. *Flexibility.* The system must fit the patients, and not vice versa. Transfer from one type of agency to another should be as easy as possible.
3. *Adequacy.* The care offered must be at least as adequate as that offered by the traditional type of psychiatric hospital service. It is not "community care" to send an old man out of hospital to live alone or in unfriendly lodgings, with only an occasional visit from a harassed general practitioner or a social worker. It is not "community care" to send a severely subnormal girl back to a family which neither understands nor wants her.

unless someone has the time and supportive family attitudes.

4. *It should facilitate social relationships.* The patient should have at least as active a social life as in the psychiatric hospital.

It is on factors such as these, rather than the size of the unit or its siting, that community care depends.

Good community care is expensive. It is probably more expensive in running costs (although not in capital outlay) than good hospital care, because the services which the hospital would concentrate have to be diffused over an area. Even in England, where roads are reasonably good and the distances involved in traveling to outpatient clinics or domiciliary visits in the catchment area are rarely more than 20 or 30 miles, traveling time and mileage costs may be considerable.

In other spheres, we take it for granted that concentration is more efficient than dispersal. We do not expect the general practitioner to visit all his patients in their own homes, because it is more economical in time and effort for the patients to come to the doctor. We concentrate children in schools, students in laboratories and lecture rooms, workers in factories, and for the same reason. If we disperse our resources for the treatment of mental disorder—and this is what community care means—we need more money, more workers, more equipment, than would be necessary for a centralized service. Community care may be better for many patients, but it is not a cheap alternative. The capital costs are lower than those of building new modern mental hospitals; the maintenance costs will almost inevitably be higher unless there is a drop in standards.

If I lay stress on the importance of maintaining standards, it is because they are very easily lowered, with often the best of intentions and the finest of descriptive

phrases. Reform in the British mental health services has a curious cyclical movement—progress never follows a straight line—and the downward trend often seems to start from the moment of greatest success. There was a great step forward at the beginning of the nineteenth century, when the system of "moral management" used at the York Retreat by the Tuke family⁸ became well known. The new county asylums provided a fresh start in care and treatment, and it was common practice for their staff to be sent to study the new methods at the Retreat before taking up their appointments; yet the county asylums settled into an institutional mold, and the system of "moral management" was never widely applied.

In 1845, a burst of optimism followed the passing of Lord Shaftesbury's Lunatics Act and the introduction of the "non-restraint system" by Conolly and Gardiners Hill. Conolly realized that the abolition of restraint was not enough in itself, and that the corollaries of this reform were the improvement of standards among nurses and new forms of activity for patients; yet his plans for a nurses' training school and a school for patients were frustrated by a parsimonious committee. Half a century of neglect and indifference followed.

Such examples could be multiplied to show that the bright promise of one decade may be the lost cause of the next. It seems likely that this is not a specifically British phenomenon, for the American report *Action for Mental Health*⁹ comments on a similar pattern in the United States. The report speaks of reform as coming in

⁸ See Jones, K., *Lunacy, Law and Conscience 1744-1845* (London: Routledge and Kegan Paul, 1955), 57-65.

⁹ Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York: Basic Books, Inc., 1961).

waves, and adds that each wave is "quickly followed by apathy, loss of momentum and professional backsliding." It would be interesting to know if historians in other countries had found a similar movement because this may be a pattern conditioned by the community's attitude toward mental health problems.

Here is one explanation: The community at large is highly ambivalent to mental disorder. The general public will readily assent to the proposition that the mental health services should be improved, or that psychiatric patients should be treated with kindness; but lip service does not lead to action. Intellect pulls one way, emotion the other. This is where the stigma of mental disorder begins. Fear of becoming mentally abnormal, of losing the power of responsible action and rational judgment, supersedes rational assent.

Fear may be projected in the form of aggression against those who provoke it—the patient, the therapist, the institution. Sometimes laughter and ridicule take the place of open aggression; thus in the eighteenth century, young dandies in London paid two-pence to see the lunatics in Bedlam; today, when we are too polite to laugh at the patients, there are plenty of jokes about psychiatrists and mental hospitals.

Sometimes the reaction is a mental block. The whole problem is pushed out of the conscious mind as if it did not exist; hence, the "conspiracy of silence."

May I suggest one more escape route? It is also possible to deal with this fear by becoming overarticulate about the problem. Catch phrases—"community care," "supportive therapy," "public tolerance" and the rest, can become almost a defense

against the reality if used often enough, a kind of incantation. We define the problems of the day hospital when we ought to be building one, or urging other people to build one. The case conference, instead of being a spur to action, becomes an excuse for a little dilettante speculation. Perhaps those of us who work in universities are particularly prone to taking refuge in verbalization, to thinking that we have dealt with a problem when we have merely described or defined it.

To sum up, I have tried to indicate some of the main problem areas in the community care field in the light of British experience: the questions of balance, dimension, finance and efficiency, selection and function. I have suggested a definition of community care based on four attributes: diversity, flexibility, adequacy, and ability to facilitate social relationships; and I have offered a few comments on the cyclical nature of mental health reform as observed in England and the United States, with the sobering thought that the downward trend could happen again.

Perhaps I ought to end by saying, like Thomas Carlyle, "Brothers, I am sorry, but I have got no Morrison's Pill for curing the maladies of society." I suppose Morrison's Pill was some nineteenth century panacea, some cure-all which failed to fulfill all the claims made for it. It is up to us to see that community care does not suffer the same fate.

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Three aspects of psychiatric rehabilitation at Fountain House

PART I

This paper is a discussion of three aspects of rehabilitation believed to be closely related to the community adjustment of psychiatric patients following their release from mental hospitals. Each may be stated in the form of a question:

First, how can the high rate of "drop-outs" be reduced among patients who are accepted for rehabilitation services?

Second, how can the capacity and motivation for productive work of the vocationally disabled patient be stimulated and developed?

Third, how can fuller rehabilitative value be taken of the place where the patient resides?

First, a brief description of the purpose and function of Fountain House, its facilities, and the various services it provides to its membership of 500 men and women

who are known in the setting as "members" rather than as "patients."

The objective of Fountain House, which was established in 1948, is to facilitate the community adjustment of psychiatric patients following their release from public and private mental hospitals. We are located a few blocks from Times Square in New York City, in a four-story brownstone building. The building is open seven days a week throughout the entire year. It was formerly a private residence, and

The authors are all on the staff of Fountain House in New York City. Mr. Beard is executive director; Mr. Schmidt is program director; Mrs. Smith, who has a certificate from the New York School of Social Work, and Mr. Dincin are social work supervisors. This paper was presented at the Institute on Rehabilitation of the Mentally Ill, held in New York City in April, 1962. The Institute was conducted by Altro Health and Rehabilitation Services, Inc., New York City.

every effort is made to maintain its home-like atmosphere. The following rehabilitative services are offered:

- (1) During the evenings and on weekends, a diversified program of social and recreational activities is offered, designed to help the members rebuild their confidence, self-esteem, and social skills.
- (2) The day-time hours at the clubhouse are devoted to helping vocationally disabled members strengthen primary work habits as well as motivation for productive work.
- (3) A program of transitional employment, developed in co-operation with commerce and industry, is offered to further the member's vocational recovery.
- (4) To strengthen the patient's capacity for independent living, a housing program has been established. Included in this program are small, attractive apartments which are made available to hospitalized patients having no home to return to, and to members who must live in substandard rooms or with families who tend to revive former tensions, conflicts, and frustrations.
- (5) During the past two years, the training function of Fountain House has been developed in co-operation with three schools of social work to provide graduate social work training. In addition, Fountain House is utilized by two universities for the graduate training of vocational counselors.
- (6) A program of controlled research has been initiated. It is designed to measure the effectiveness of the rehabilitative services offered at Fountain House.

These multiple services are supervised by a staff consisting of eight case workers, a group worker, two sociologists, a psychologist, a psychiatric nurse, and four lay workers. The services of two psychiatric consultants are engaged on a part-time basis for the handling of emergencies and case consultation. A group of 100 trained volunteers is active in all phases of the program.

PART II

We may now turn to the question of "drop-outs," those individuals who seek

rehabilitative services, are accepted by the agency, and then fail to reappear. Since the summer of 1959, Fountain House has carefully studied the attendance patterns of some 300 new members. It was found that 33 per cent failed to make even one return visit to Fountain House during the first month following acceptance in the program. Over a longer period of time, we find that almost half of these members made no visits whatsoever to the center during their fourth, fifth, and sixth months of membership.

These figures, we believe, show that applicants for rehabilitation have great difficulty in becoming active participants in rehabilitative facilities. Unfortunately, individuals who fail to become active do not do so because of their ability to achieve a successful community adjustment. Quite the contrary. Our follow-up studies reveal that some 55 per cent of the members who become rehospitalized are those who failed to make more than five return visits to the rehabilitation center.

Clearly there is a need to develop more effective methods and procedures which will enable such applicants to utilize the available services. A further point gives emphasis to this view. Research data acquired from a controlled experimental study show that the rehospitalization rates of a randomly established control group—which did not undergo the Fountain House services—approximated 60 per cent within a two-year period following last hospitalization.

In the mental health field, hospital personnel, outpatient clinics, and the families and friends of the mentally ill are well aware of the difficulties encountered by the psychiatric patient in effecting a sound community adjustment. Because of this awareness, there is undoubtedly a selective factor guiding the referral of patients to

such centers as Fountain House. This is as it should be, for, theoretically, our primary concern must be in serving those patients who will have the greatest difficulty in making a community adjustment.

We must, therefore, be determined to establish a rehabilitative relationship with more of the applicants who come to us for help. We know of the high tendency for relapse. We know also of the high tendency to withdraw from the rehabilitative process. Far too many patients tend to become as "home-bound" as the physically handicapped once were. They remain isolated and withdrawn from the community, confined to their families' homes or to unattractive rooms in New York City tenements. Under such circumstances, their limited capacity to adjust deteriorates further, making it more difficult for them to achieve a social recovery.

The following two case examples illustrate the steps which were taken to counteract the tendency of a patient to withdraw from the setting following intake.

Case 1

An attractive, neatly dressed 32-year-old woman was taken on a tour of the House following her intake interview. Pleasant and friendly-appearing, and seemingly positive to the setting and to the other members, her negativity to rehabilitative involvement was not picked up at intake. She was introduced to another staff worker, who casually asked if she would be coming regularly to Fountain House. The client promptly replied that, while Fountain House was a very nice and pleasant place, she would under no circumstances be coming back.

Furthermore, it was clear to her that she must return that very afternoon to the hospital, where she had previously undergone two hospitalizations, totaling over three years. Only there could she truly get well, she said. The worker recognized that her plan might be best, but nevertheless discussed opportunities for her, including participation in the day program, placement in the

transitional employment project, and possible residence in a Fountain House apartment.

The worker saw that a basis of involvement had not been accomplished, and therefore secured a promise from the patient that she would discuss this plan with her psychiatrist. She then departed for the hospital. Early the next morning she reappeared, went to talk with the worker, and said that her doctor at the hospital had urged her to return and try out the worker's plan.

She made it quite clear that although she appreciated the worker's interest and hopeful attitude, she did not believe that the plan would be of any real help. In the subsequent six months, the patient became active in the clerical program, was placed on the employment project, and is now considering a Fountain House apartment.

Case 2

George, age 44, had been hospitalized for two years. He first learned of Fountain House through a newspaper article. He was accepted for membership at intake. After two days of nonattendance at Fountain House, a home visit by two members was arranged. Since they did not have the floor number of his apartment, the visiting team contacted the apartment superintendent who was able to identify the member through their description of him.

Initially, George was afraid to let them in, but readily did so after learning they were Fountain House members. The home visit lasted for three hours; during the visit ginger ale and ice cream were served. The members, who dictated their report following their return to Fountain House, indicated that George wanted them to stay even longer; that he was lonely and enjoyed having a visit. When they asked why he had not returned to Fountain House, George explained that he had a morbid fear of traveling on the subway. The members explained that he could get to Fountain House by bus, and they arranged to pick him up the following morning so they could show him the bus route. This was done, and George became involved in our program.

Reaching out has many implications. For example, 90 per cent of all applicants at Fountain House are eligible for membership. Therefore, the major objective of the intake process is not to establish eligibility, but rather to define with the appli-

cant an area of interest which will enable him to participate. A link between the patient and the agency must be established. Recognizing that 80 per cent of our applicants have a diagnosis of schizophrenia and that one-third have undergone more than three hospitalizations, discussion at intake cannot be focused on the client's motivation to get well, or on his need for the rehabilitative services of Fountain House in facilitating his community adjustment.

The patient's capacity for attachment to the setting, his willingness and desire to participate, can only occur if the agency program fulfills a need which is significant to him. There is a wide range and diversity of needs which the applicants reveal to the skilled worker at intake. For example, many patients will come back to Fountain House because free refreshments are offered or because they can buy lunch for 20 cents, or because one can watch television or simply sit by oneself in the lounge. A patient may covertly express his need for rehabilitation by rigidly insisting that he wants to "help others who are sick and in need of help."

Perhaps the providing of emergency financial aid or overnight shelter is the first step in establishing initial participation. Something in the setting must capture the interest of the patient, something which stimulates him to come back. With each new applicant, there is the necessity of seeking out this basis for participation. Subtle, interpersonal factors are most relevant. It is desirable, therefore, that the applicant's contact at intake not be confined to one worker alone. Our intake process includes a tour of the facilities and introductions to other members and staff. It is believed that this procedure increases the applicant's chances of finding some aspect of the program or setting which can be significant to him.

While the applicant's handling at intake is crucial in determining later participation, other facilitating steps can be taken during the first few days following intake. Of course, there must be an immediate awareness of an applicant's failure to make return visits. Through the keeping of daily attendance records, such information comes immediately to the attention of staff, and steps can be initiated to prevent the continued process of withdrawal.

For example, home visits can be made by staff, volunteers and members. There is a high degree of receptivity to such home visits and other expressions of interest. Seldom does either the patient or his family insist that contact with Fountain House be terminated. Frequently, continued home visits need to be made. In this way, the rehabilitative relationship is actually initiated in the home rather than in the environment of Fountain House. The objective of such visits is identical to that of intake; namely, to establish a level of patient participation. Other means, of course can be instituted. Telephone contact is frequently of value, as are letters and postcards. Invitations to special events may be another avenue for creating interest.

In conclusion, there are many more applicants for rehabilitative services than there are programs which can accommodate them. Thus, any center such as Fountain House can easily have a full and active membership without having to give any special consideration to those patients who withdraw following intake.

It is important, however, to give consideration to this particular group of patients. Not only do they require help and assistance, but by reaching out to them, by finding methods and techniques which will enable them to undergo services, we will not only be of assistance to them but will increase our effectiveness in working with

those who can more easily achieve participation in a rehabilitative setting. Our efforts in this direction—on the basis of preliminary research findings—indicate that the various methods of reaching out which have been utilized have resulted in a marked increase in patient attendance. We, of course, will continue these efforts.

PART III

With regard to the responsibility of a rehabilitation center to provide services designed to develop primary work habits and job motivation in the vocationally disabled patient, the following tape-recorded comments are presented:

"I've been at Fountain House a long time. . . . I've done practically everything here. . . . I've swept floors, carried chairs, set tables, worked in the kitchen, helped cook, done the dishes. . . . It makes me feel better. . . . Before, I just had time to kill. . . . I didn't know what to do with myself. . . . I got lost, so I got found.

"People can't get started working right away. . . . First they got to get the feel of things. . . . When a guy gets a new job he feels scared, timid. . . . You don't give a guy like that anything to do until he gets the feel of things. . . . Then you say, 'Would you mind doing this?' He says 'I don't mind'. . . . When he sees other members doing the same thing, he feels good. . . . If they can do it, why can't I? . . . After a fellow gets used to seeing others work it's not too long until he wants to work too. . . . You put occupation in a person's mind and body and the weeds will go away from him. . . . He gets to feel he is wanted, not resented. . . . This comes gradually. . . . I don't remember how I heard about Fountain House. . . . I have been here a long time. . . . I'm not sure how long. . . . The past is just a blank. . . . At Fountain House I can sit down and relax and feel like somebody. . . . Even if I'm nobody. . . . Recently I started a job, a placement, as a delivery man. . . . When a person gets his first paycheck he feels good. . . . He can get . . . knickknacks, the things he wants."

When we recall the high tendency for rehospitalization and marginal community

adjustment of our population, it can be expected that members referred to Fountain House will not achieve a high degree of vocational adjustment. Follow-up information has supported this view. Only one-third of the applicants to Fountain House are employed at any one time following their release from hospital. About 75 per cent of our applicants are single and practically none have any responsibilities for managing a home. Yet, in spite of availability for work, more than 40 per cent are unable to secure even a single day's work during the first year following application to Fountain House. Of those who do work, the adjustment is poor and job turnover is high.

Typically, Fountain House members are financially dependent on family or public welfare. Their daily lives are spent in marked unproductiveness. Interpersonal difficulties are obvious, and the motivation to perform productive tasks is diminished. The necessary prerequisites for vocational training are lacking. Clearly such patients need a specialized service geared to their prevocational needs.

The approach selected by Fountain House was to utilize the rehabilitative value of certain activities directly related to the operation of the house during the daytime hours. One problem stood in the way, however. Practically no patients ever appeared in the morning hours. Only a handful would come in the early afternoon. Our immediate objective, therefore, was to get more of our members into the house earlier in the day. Our approach was to serve a free breakfast at 9:00 A.M. This plan met with immediate success.

The serving of breakfast, of course, launched our first activity. A great deal of help was needed to prepare a breakfast of fruit juice, toast, cereal and coffee. Because our staff at Fountain House is small, it was

not possible for the worker who opened the house in the morning to perform all of these activities. It was necessary to set up tables, make coffee, prepare the cereal, serve the breakfast, clear the tables, and wash dishes. The social worker's need for member participation was most apparent, and the members joined in. Additional activities were then set up by other professional staff; for example, the cleaning of the house—dusting, sweeping, scrubbing, floor polishing, window washing. Again members joined in. In addition, some 20 members a day helped out with all the varied office and clerical routines in our office.

In each of our activity areas, be it the luncheon program, the clerical office, or the cleaning and maintenance of the house, professionals assumed direct responsibility, with members and volunteers working next to them in the performance of all tasks. A significant kind of communication developed. Members inevitably acquired a sense of belonging, of being needed. When they were absent during the day, it did not go unnoticed. All of the tasks they performed were intimately related to the environment of the house.

The jobs were not manufactured or created for educational or "busy work" purposes. Whether they did well or poorly, it was noticed. A process of approval and recognition of members' contributions to the milieu prevailed. There were opportunities for participation for the most passive member, and as the individual's motivation and capacities expanded, so did his opportunities. A quality of mobility characterizes the day program; more complex jobs and levels of responsibility can readily be assumed.

It is by no means clear by what processes the member changes his values and attitudes, his hopes, expectations, and concept

of his future. However, there is present in the daytime environment a hopeful and optimistic attitude in respect to each member's future. The member himself is surrounded by those who are not doing as well, and also by those who lives are moving ahead. The member, through his active participation, is no longer socially isolated and uninvolved in a group situation. His daily functioning is no longer dominated by his illness or residual symptomatology. His participation, his performance in the day setting, reflects his strengths and capacities. His relationships to others grow out of his role in the setting, a role of doing, of contributing, of accomplishing. It is believed that this is a restorative process, one which contributes to the patient's social recovery.

It is of interest to note that the member's initial perception of the professional staff worker reflects his past experiences with professional personnel. The member anticipates a discussion of problems and difficulties. Appointments and interviews are expected. It is believed that the appropriate environment for contact with the professional is a room with two chairs and a desk.

Invariably, the member goes through a period where he regards the professional as different from the other workers he has known. The staff worker, however, acquires a very intimate and extensive understanding of the many facets of a member's personality and difficulties, his strengths and capacities. The worker utilizes the work environment for the purpose of enabling the member to establish a relationship characterized by those qualities which typify more normal interpersonal relationships.

We believe that in this way, the patient's perception of himself is gradually modified.

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He experiences a human relationship based upon his strengths rather than upon his problems and pathology. The following recorded excerpt is an example of the process of member involvement in our program.

"I've been at Fountain House a year. A social worker sent me. At first I didn't come. The social worker sort of inveigled me to come down. After a lot of effort I finally managed to get here. I grew away from people by being 20 years in the Rockland State Hospital. . . . It is hard getting used to them again. . . . I never thought I would leave the hospital. I first came to Fountain House with my sister-in-law, Helen. I remember my first day. I didn't look at anyone. I didn't talk to anybody. I just sat . . . like a statue. Then I got started working in the kitchen. One day Mrs. Gardiner, the housekeeper, asked me to help out, and I started to fix vegetables and prepare for dinner. I took to it like a duck takes to water, and I have been doing it ever since. I keep active. Now I'm used to the people. I make the coffee in the morning, help cook lunch and wash the dishes. I prepare refreshments in the afternoon and wash up after that.

"I am now on welfare, living at a Salvation Army residence. For the future I was thinking of getting some work, something like I am doing at Fountain House, helping in a home somewhere."

Various case examples can be cited of members who have achieved a high degree of involvement in one of the four areas of the Fountain House day program. Typically, at intake, such members have little or no work history, are financially dependent and are lacking in motivation for work, including those habits, routines and attitudes which are essential for the performance of productive work. Through participation in the day program, the majority of these men and women are able to effect a prevocational adjustment within the setting. Fortunately, a good number can move directly on to jobs of their own.

Others, however, despite their adjustment within the setting, are unable to assume regular employment. It is believed that such members are severely threatened by the thought of going to work. There are undoubtedly many reasons underlying their fears and anxieties. We know that their feelings of confidence and security are related intimately to the Fountain House setting and that they often avoid employment because it would cause an abrupt separation from the day program. Also, their financial dependency on family or public welfare would, from their point of view, be endangered if they became wage earners.

Therefore, we sought and obtained the co-operation of commerce and industry. A group of employers in New York City agreed to give to Fountain House one or more of their job positions, which we could use for purely rehabilitative purposes. These jobs, paying regular rates, ranged from clerical work in a large Fifth Avenue store to messenger work in a small printing company. A Fountain House member is permitted to work on a job placement for as little as one hour per day, if necessary.

Each job is performed first by a social worker in order to determine the performance standards which the member, when placed, must meet in order to achieve a successful job experience. Also, the worker is able to identify those tensions unique to the job environment. By working on each new job placement, the professional worker is also able to secure the interest and co-operation of fellow employees. He can explain and interpret the rehabilitative function of the job placement which is to be initiated.

Each job placement is limited to three or four months. Hours of work are gradually increased as the member's tolerance for work and self-confidence increases. Of

course, the worker can always accompany the patient at any time during the job placement. This is found to be particularly helpful when the member is experiencing difficulties on the job. After a member has demonstrated to himself and to his employer his capacity to perform work, he then moves on to a job of his own, the placement being used over again by another member. One member had this to say in a taped interview:

"I had been in the hospital for almost two years . . . and about four times before that. All I can remember is flying around to hospitals here and there. . . . When I got home in June of 1959, there wasn't much for me to do to keep occupied. . . . I would go shopping with my mother. I looked for a job but I did not know where to find one, and then I was too sick to go to work. Then I came to Fountain House. . . . A young social worker from the aftercare clinic came with me the first time. I wasn't too active at first, but I wasn't too stationary either . . . I started working in the office on the fourth floor . . . helped take the attendance the same as it is being done now, and I went on errands for Eileen and Mr. Schmidt. This kept me occupied and I did not seem to feel any pressure . . . I began to think that if I could prove to myself that I could do a job at Fountain House, get up in the morning and eat lunch with other people and try to see if I could do a day's work, then maybe Fountain House could get me a job.

"I am on a placement now . . . I wanted to work and yet I didn't. . . . Thought it would be too much for me and I didn't want to go back to the hospital, but I wanted to make money. The placement has worked out fine. I started with just three days a week from 2:00 to 5:00 P.M. I made \$9.90 in my first week. Now I am working five days a week from 9:00 A.M. to 2:00 P.M. It's something I should have been doing a long time ago. But now I have something to look forward to . . . something that is giving me a chance. I have purchasing power now and I can walk into a store and buy something for myself. That's something I have always had to ask my mother for, money. It was never my own. Now I can buy her candy sometimes, and I give money to my church and I know

where it's coming from. I can see where it's going if I don't have to pay too much income taxes."

At the present time, 14 New York firms are providing job placements to Fountain House members. Each day over 20 Fountain House member work on placements, and their total earnings approximate some \$35,000 a year. These men and women are no longer full-time at Fountain House. They are reporting for work in a normal work environment. They are undergoing a learning experience, many for the first time. They are discovering that they are capable of performing productive work; they are receiving wages, and are becoming less dependent on welfare or on their families. The rehabilitative quality of the transitional placement maintains for them an important link to Fountain House. Yet a process of separation is underway, one which will enable many members to obtain regular, full-time employment.

It is believed that commerce and industry can play a most vital role in our efforts to return increasing numbers of vocationally disabled mental patients to productive work. Clearly, this vast resource represents a great potential in the vocational rehabilitation of the mentally ill.

The third area of our discussion concerns the Fountain House apartment program. We present the following case example:

"Louise, a woman in her forties, had been hospitalized for more than five years at a state hospital following the death of her mother. Her only living relative was an invalid sister who was unable to give her a home. The agency offered her the opportunity to share one of its apartments. Within a few weeks she left the hospital with the agency worker and came to the apartment, where she met her roommate, a woman a few years younger. Both of these women were of a passive nature, but they found that they had many things in common. They were interested in keeping house, in cooking, and from the very start began to plan their meals

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together. They have been most companionable. Their apartment is always orderly and they have made a number of attractive changes. Since Louise moved in, her roommate has made a better adjustment than when she lived alone.

"Louise comes daily to Fountain House, being active in the luncheon program. When not busy in the kitchen, she likes to sit in the lounge embroidering, and she has shown a quiet friendliness to other members. Louise now visits her invalid sister at least once a month, and has even looked up a distant cousin within the last few weeks."

This member represents those men and women who remain in mental institutions largely because they have no home to return to. Their continued hospitalization is due less to their clinical adjustment than to the fact that adequate housing facilities are not available to them. In the case of Louise, hospital personnel were reluctant to return her to the community, to live an isolated existence in a furnished room. Such an environment, they feared, would reactivate her symptomatology.

There are other groups of patients, however, whose need for suitable housing is equally great. It is unfortunate that many patients must reside with families who tend to revive old conflicts, tensions, and feelings of failure and frustration. The effectiveness of rehabilitation services is inevitably reduced or lessened when such patients continue to reside in damaging environments. A third group of patients includes those who return to the community to reside in lonely, single, substandard rooms. This certainly does not facilitate their community adjustment.

In drawing attention to the housing problems with which so many former mental patients must struggle, we are not suggesting that rehabilitation centers must do "everything" for its clientele. Only one point is emphasized; namely, that personnel in rehabilitation centers inevitably recog-

nize that unsuitable housing exerts a negative influence upon the posthospital adjustment of the patient. We believe it is the responsibility of such personnel to direct their planning toward the solution of this problem. Establishment of residential settings represents one approach. Placement in family care represents another.

In this paper, we are discussing a third approach, one which involves the securing of small, modest, but attractive apartments located in the community which can be made available to selected patients. Volunteers can be attached to such apartments and through their weekly visits, can help strengthen the capacity of the patient for independent living. One of the activities of the rehabilitation program can be the refurbishing of such apartments. Furniture and other necessary items can be secured by utilizing contributions from the community.

The residents of the various apartments can exert a most positive influence upon each other's adjustment. All residents attend weekly meetings which are held at Fountain House. These meetings are friendly and informal; refreshments usually are served. Sometimes meetings are held in a member's apartment. The following excerpt of a worker's recording describes certain aspects of these meetings:

"At our meetings there is always discussion on how members are getting along with each other in their apartments. Are they able to cope with the housekeeping tasks? How often are they cooking meals and eating together? Are they changing their bed linens on a weekly basis? What time are they retiring at night?

"With the newer residents, the discussion is frequently in terms of 'How is it anybody's business what time we go to bed? What right do the neighbors have to complain? If we can't sleep at night, why can't we play our radios and TV sets?' Sometimes there are disagreements between the two members who live together because one wants to retire early, the other stays up late; one wants the windows open, the other

closed. These subjects are taken up one at a time, and as a rule the members themselves help to resolve the difficulties, usually by pointing out the kinds of agreements which have been made in the past. A recent development has been the celebration of each resident's birthday."

We believe the community can accommodate the returning patient not only in terms of foster homes and half-way houses, but also by utilizing living environments typical of the community itself. Currently, Fountain House has leased some 10 apartments located throughout New York City. Generally, two members reside in each apartment. In a number of instances, members are able to assume full responsibility for monthly rental. On an over-all basis, a subsidy of approximately 20 per cent is required. Since the apartments serve as a temporary residence for three to nine months, the occupants are helped to make plans for their future living arrangements—usually a lease of their own.

One last case example is presented to highlight some of the significant aspects of this paper:

"Mary, age 42, had been hospitalized three times during the last seventeen years, for a total of five-and-one-half years. When in the community, she remained financially dependent on public welfare. She always rose late in the afternoon, retiring early in the morning. For some two years she joined in the social-recreational program at Fountain House, always arriving in late afternoon. She was well-liked by other members, but was fearful of becoming involved in any of the day program activities. On one occasion, when asked to pick up a phone, she became anxious, stating that she underwent her first breakdown years ago while working at a switchboard.

"One afternoon, however, she was willing to help with a large mailing. She was exceptionally fast at folding inserts and did not appear to be upset when participating at this level. Gradually, over a period of two years, Mary's clerical participation increased. She began to perform other clerical routines in the house, and her time of arrival became earlier each day. Routinely she

spent the entire day with the members in the clerical office on the four floor. Mary eventually achieved an excellent vocational adjustment within the setting, but was afraid to move on into a job of her own. While other members she knew were able to do so, she insisted that she would become too nervous and upset if she went back to work. Her main task, she felt, was to avoid a fourth breakdown. She had adjusted to her welfare department income of \$88.50 a month. Also, she had grown accustomed to a small, unattractive, furnished room.

"We believed Mary was an excellent candidate for the transitional employment project. She was told one day of the plan for her to work for simply an hour a day at our Lane Bryant placement, as part of her experience at Fountain House. She would be accompanied by the social worker. Upon completion of her first day's work of one hour—in the mailroom—for which she was paid, she commented to other members and to staff that there was no problem at all in working this length of time. The job placement did not represent a threat to her as did a regular job which would be unrelated to Fountain House.

"Within a period of a month, Mary achieved full-time employment at Lane Bryant. The worker, of course, spent less and less time with her, and within two weeks she was working alone. At that point, one outstanding reaction developed. She had received a full paycheck for the first time in many years. Now, no longer on welfare, she was able to use her income for purposes she had long since abandoned. She proudly showed a new pair of shoes to fellow members and staff.

"Toward the completion of her third month, the services of the New York State Employment Service were secured. The Service found helpful the detailed evaluation of her job performance during the placement. Arrangements were made for a job referral to a store similar to Lane Bryant, located a few blocks south on Fifth Avenue. Her first contact with the employment service was at lunch time in the Lane Bryant cafeteria; at this time a counselor from the employment service interviewed her. Upon completion of her placement one Friday afternoon, she began regular employment on her new job the following Monday.

"Mary is one of the members of Fountain House who had easily become attached to the recreational program. Her full participation in the day program was accomplished over a two-

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year period. Her job placement was typical and successful in that she started her placement for about one hour a day, accompanied by a worker, reaching full-time within a few weeks and completing her placement at the end of some three months. She moved on immediately to a job of her own, and she has continued to remain at her present position for some three years. Clinically, her diagnosis remains unchanged. There are still periods of depression and anxiety. However, she has achieved for herself a high measure of social recovery.

"During her job placement, Mary moved into a Fountain House apartment. After a stay of some six months, she moved into an apartment of her own with the roommate with whom she had shared the Fountain House apartment. Fountain House provided her with the necessary deposit, which she repaid gradually. She is now residing in Brooklyn with her two daughters, a goal which she had been unable to achieve following her separation from her children when they were infants."

PART IV

In summary, the rehabilitation program of Fountain House tends to attract psychiatric patients who often have great difficulties in effecting a community adjustment following hospitalization. Not only is there a high tendency for relapse or rehospitalization among such patients, but their vocational capacities are frequently most limited. Unfortunately, their need for rehabilitation services does not necessarily result in a high degree of participation in such services. The tendency to withdraw, following intake and acceptance, is high. It is essential, therefore, that methods and techniques be developed to facilitate participation in rehabilitation services. When such procedures are initiated, a reduction occurs in the drop-out rate.

Because of the varied needs of the psy-

chiatric patient, differential services are required, and it is necessary that the social recreational base of the expatient club be extended and broadened. It is believed that programs of personal adjustment training, designed to establish primary work habits and develop motivation for productive work, will enable many vocationally disabled patients to assume normal work roles in the community. This objective can be facilitated by securing the participation of commerce and industry in the vocational process. The mental health field has a great need for resources which have a built-in potential for serving the large numbers of individuals who require assistance. Careful examination must be made of the various possibilities which the community itself including its own institutions, can play in the rehabilitative process.

Lastly, the housing needs of the psychiatric patient require more adequate handling. Far too many patients remain in institutions merely because they have no home to return to. Many others, residing in the community, require living situations which will contribute to their social recovery rather than retard it. The apartment program of Fountain House offers a promising approach, one which is in keeping with the principle of strengthening the patient's capacity for independent living.

In conclusion, such centers as Fountain House, through experimental programs, must continue to seek out more promising methods of rehabilitation. The need for such services is indeed great, and our pursuit must be energetic and within a research framework. Only in this way will the essential function of the rehabilitation center be ultimately fulfilled.

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Changing perceptions of mental health

The psychiatric subculture is in the midst of its second revolution in this century in its way of perceiving the problems of its concern—mental illness and mental health. I propose to illustrate some of the problems of social perception by referring to the ways in which this subculture approaches these problems.

First, it may be well to describe something of the nature of social perception. Bernard Berenson, who was no mean observer of the human scene, observed that "the nature is a chaos, indiscriminately clamoring for attention. . . . To save us from the contagious madness of this cosmic tarantella, instinct and intelligence have provided us with stout insensibility and inexorable habits of inattention, thanks to

which we stalk through the universe tunneled in and protected on every hand, bigger than the ants and wiser than the bees" (2). Berenson points out the healthy side of the structuring of perception; man is thus saved from the confusion of seeing too much or, as James Miller puts it, from "information input overload" (23).

A less constructive consequence of this tendency is that the observer may perceive only what he expects to see and may thus miss very significant aspects of the scene before him. Scientists are by no means immune from this, but they do learn ways of perceiving their subjects; these ways are called methods.

Whitehead has pointed out the dangers of being trapped by such methods of perception. He said: "We all start by being empiricists. But our empiricism is confined within our immediate interests. The more clearly we grasp the intellectual analysis of a way regulating procedure for the

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sake of those interests, the more decidedly we reject the inclusion of evidence which refuses to be immediately harmonized with the method before us. Some of the major disasters of mankind have been produced by the narrowness of men with a good methodology" (37).

This structuring of perception has been observed and studied experimentally by the use of perceptual demonstrations developed by the late Adelbert Ames, Jr., in New Hampshire. By presenting subjects with a series of paradoxical demonstrations, it is possible to show that perception involves an active process of organizing stimuli in terms of expectations or assumptions which have been built out of experience. For example, in a distorted but normal appearing room a boy may appear larger than a man—the assumption of rectangularity in a room is so strong that it persists in the face of an obvious absurdity.

From this kind of observation Hadley Cantril and his associates have developed the view first suggested by Dewey and Bentley that perception depends on a process of transaction involving the organism and the environment simultaneously (9, 4). In this view, man builds up a series of assumptions or expectations about his environment on the basis of his experience. He then interprets new experience in terms of these assumptions. And the way in which he perceives becomes the basis for action.

This is fine as long as it works; as long as the constancies of the environment correspond with the constancies of internalized assumption. When the environment does not respond as expected, however, when a hitch occurs in the transaction, it becomes necessary to modify the assumptions which have "worked" heretofore, or to deny the unexpected behavior of the environment.

Social perception is based on a similar experience. Man exists in transaction with

a social environment; he comes to expect certain constancies and he perceives his society in terms of these. This model is similar to the consensual validation of H. S. Sullivan (34). These social constancies are provided in the first instance by the family, and, later, in a widening circle of transaction with the community, the nation and the general culture. One comes to expect a high degree of predictability in transaction with his environment, and shapes his action in terms of this predictability; simultaneously, the society expects a high degree of predictability from the individual and treats him accordingly.

Now, hitches arise in the social transactions between the individual and environment when the expectations of one are not met by the other. The individual whose social perceptions lead him to act at cross-purposes with the society is not likely to have his expectations continuously confirmed, and he either alters his assumptions or becomes alienated from the society. And assumptions do not change easily.

As the historian Hans Kohn has observed, in discussing the assumptions which are associated with nationalism: "It has always been easier for men to sacrifice their lives and even their fortunes than to abandon their habitual ways of thought and feeling, their prejudices and traditions" (18). Fortunately, the penalties of persisting assumptions are not always so serious as in the case of nationalism.

This problem of alienation from society has become exceedingly acute in this century, especially since World War II, for two processes have made themselves felt: the rapidity of changes in society itself and the mobility of persons into new social settings. In traditional societies, the individual could be relatively certain that his assumptions would continue to work, and he could predicate his action on these. At the

present time, the impact of technical and social change creates a considerable risk that assumptions built up over a life's experience will not necessarily prove a correct basis for action.

Secondly, since societies are highly differentiated in the rules and practices which are considered appropriate transactional modes, what works in one society or one subculture will not necessarily work in another. The extensive mobility of persons within and between societies, which characterizes the present period, inevitably leads to hitches between the expectations of individuals and the responses their actions elicit. The age of change, therefore, is also an age in which the risk of alienation is increased.

Now, let us return to the consequences of these observations for the two revolutions in psychiatric thought. The first, being largely historical, is the easier to discuss.

Nineteenth-century psychiatry modeled its approach on nineteenth-century medicine; it was basically concerned with a disease concept of mental malfunctioning. The problem was seen as one of developing adequate classification of psychiatric disorders, of discovering their natural history and of searching for the etiologic agent, preferably to be found in specific nervous system pathology.

This method was pushed to the limit, but the results were not entirely satisfactory. True, a number of conditions were identified, their causes discovered and eventually rational treatments were developed, as on the model of general paresis. However, too little progress was made with a vast array of disorders which certainly produced profound suffering and were certainly mental in nature. This failure of a method to solve the problems with which psychiatry was concerned led

to a questioning as to whether the concepts, the assumptions with which psychiatry was working, were adequate to comprehend the problems in the psychiatric province.

It is certainly no accident that the two men most responsible for a change in view were both outstanding pathologists, excellently grounded in the disease concept. Sigmund Freud and Adolf Meyer developed their new viewpoints, which coincided in fundamental respects, only after they had far-reaching experience with the specific disease concept, and had found this inadequate to explain many of the problems which they met. Their response was identical; it was to develop concepts of the *functioning* individual as possessing the qualities of mental illness or health. The individual and his history, the way he functioned in relation to the environment, became the focus of psychiatric attention.

It is noteworthy that even though this new approach encompassed the disease concept (that is, it recognized that individual functioning could be disrupted or distorted by specific disorders), the new approaches were not instantly seized by psychiatric practitioners. The "classic" approach persisted for some time; the new views were bitterly resisted in psychiatric congresses; and only gradually, especially with the appearance of a new generation of psychiatrists who had no assumptions to change, did the functional view come to be the standard conceptual approach of the specialized psychiatric subculture.

It is notable, also, that this viewpoint led to some tension between psychiatry and the main body of medical thought, although medicine has quite generally come to adopt a more functional view in its own right. This, I believe, is a fair example of the persistence of assumptions about the nature of what is being perceived, of the

necessity to alter these assumptions when they fail to bring expected results, and of the continuing resistance to the process of change. But the social perception of the psychiatric subculture did change, and that of psychiatrists changed with it, all with some trauma and dislocation. As a result of this change, psychiatry undoubtedly became more effective in dealing with a wider range of mental illness, especially with the development of the psychotherapeutic function.

The second revolution of psychiatric conceptualization is still in progress, and the final shape it will assume can only be extrapolated from the present trends. In general, however, the key discovery which has been in the process of being made and elaborated is that healthy functioning is not a property of the individual alone, but one of the transaction of the individual with his surroundings.

The ground for this new shift had been prepared by Freud and Meyer and by the psychiatrists who followed them, for the functional approach had taken considerable account of the individual's relation to his environment. However, this did not make easy the acceptance of the views of such representative pioneers as Horney and Sullivan. Karen Horney, in *The Neurotic Personality of Our Times*, was one of the first psychiatrists to point out that the demands of society can create neurosis (12). H. S. Sullivan followed with his descriptions of the acculturation process and his view that "a personality can never be isolated from the complex of interpersonal relations in which a person lives and has his being" (34).

Again, as in the earlier revolution in concept, these thinkers had found themselves dissatisfied with the power of the concepts current in psychiatry to explain the phenomena which they observed, and,

like the earlier pioneers, they had refused to continue to apply assumptions which did not work. To put it another way, their perceptions were not limited by the assumptive systems of psychiatry; consequently, they began to modify the assumptions to square with their observations and to create new assumptions which they thought might increase the validity of explanation and the effectiveness of treatment.

World War II brought with it a massive cross-cultural exposure; it caught men in the grip of social forces which they could not control; it brought psychiatrists out of their consulting rooms into the community, especially the military communities; it faced psychiatry with the problems which arose in the process of the resettlement of displaced persons; and it initiated a period of rapid social change. All of these factors served to draw attention to the interdependence of the individual and his society.

The focus of psychiatric conceptualization on the individual had left the psychiatric discipline ill-equipped with assumptions and methods to deal with these new problems. So psychiatry turned vigorously to developing means to conceptualize the interaction process, often in collaboration with social scientists. Building on the earlier observations of such anthropologists as Sapir (29) and Kroeber (19), a number of teams began to work together to construct models of the interaction process; Murray with Kluckhohn and Kardiner with Linton, for example (17, 16). In a special tour de force, Erikson combined his talents as sociologist and psychoanalyst to produce his study of the differential patterning of childhood development in various societies (10). Finally a whole spate of studies of mental illness and health in various cultural settings have begun to ap-

pear, often from interdisciplinary settings—such as the Section on Transcultural Psychiatry at McGill—and from teams at Cornell and the University of Buffalo (39, 25, 26).

These studies consistently show that there is a considerable variation in the rate and forms of mental disturbances in differing societies. Along similar lines, research on the effects of migration have shown that persons who have been healthy in one society may fall ill in the process of adapting to another (24), or even that childrearing practices which appear to contribute to health in one setting fail to do so when they are continued in a radically different society (35).

Another series of investigations, stimulated by the same new perception, are the epidemiologic studies of mental illness. These have usually involved the collaboration of psychiatrists and sociologists. Examples of these are the studies of New Haven, led by Hollingshead and Redlich (11); those in Nova Scotia in which Hughes and the Leightons have been instrumental (13); and the study of mid-town New York City by Srole and his colleagues (32). These have all led to the same general conclusion: that mental illness is differentially distributed in the population in terms of social status and social integration. This has led Redlich, for one, to state that "meaningful propositions on normality can best be made within a specific context . . ." (27).

Even closer to home is the study of the social interaction within the psychiatric hospital. Stanton and Schwartz, for example, have shown that "individual" symptoms—such as enuresis—are influenced by events in the hospital society, and Caudill has examined the way in which the psychiatric culture itself is reflected in patient symptoms and behavior (33, 8).

Meanwhile, still other groups of psychiatrists have turned their attention to the intimate society of patients—their families. Lidz and his colleagues in New Haven, Nathan Ackerman in New York, Spiegel in Cambridge and Mendell in Texas have all conducted studies which demonstrate that complex interactions within the family milieu are involved in the occurrence of mental illness, if not directly causal, at least in relation to forms and course of the disturbance (20, 1, 22, 31).

Finally, impressive experimental evidence has accumulated on the effects of isolation. Hebb in Montreal and Lilly at Bethesda have demonstrated that when external stimuli are reduced by isolating individuals, a series of mental phenomena soon follow with inability to concentrate, confusion, disorientation and even hallucinatory experiences (21). The dependence of the individual on a more or less continuous input of stimulus, on receiving some patterned response from the environment, is strongly indicated. Once again the inseparability of the individual from his surroundings is borne upon us.

All of this work, and more like it, points to the conclusion that mental illness or health is not a function of the individual alone, but is rooted in the transactions of the individual within his social surroundings. Although this point of view has penetrated rather deeply into psychiatric thinking, it still has not become the basis for a coherent and consistent conceptual framework, a new and disciplined pattern of assumptions with which psychiatry can approach its subject matter of mental illness and health.

The present confusion in psychiatric thinking is probably due in large part to the transitional phase of this new revolution. This confusion is nicely documented in the first monograph of the Joint Com-

mission on Mental Illness and Health in which Jahoda reviews current concepts of positive mental health (14). She shows that no adequate criteria of mental health or even of mental illness, except in extreme cases, have been defined or agreed upon. But it is clearly recognized that mental health depends in some crucial way upon man's relation to his environment, the same conclusion Redlich had reached in the paper cited earlier (27).

It appears from these studies that the fundamental stumbling block is the persistent attempt to define mental illness or health as individual qualities, as something possessed by the individual taken more or less in isolation from his social environment, or at least as he reacts or adapts to this environment. This may be an example of the persistence of assumptions which guide our perceptions even after they prove unable to explain the phenomena before us. For, as I have tried to show, much evidence has already accumulated that mental illness or health depends on the processes of transaction between the individual and his environment.

Such a view requires that a definition of health or illness will have to include this transactional process. To measure health, then, the individual and his social surroundings would have to be examined simultaneously, and the interdependence between them assessed. Perhaps a new definition of mental health would include some kind of appropriate transactional relationship involving both the individual and his environment. This has been occasionally articulated, as in Ackerman's statement that "mental health is, in large part, an expression of social process," but it is still extremely easy to retreat to concern with mental health as an individual function.¹ (1).

The fact is that although no such general concept has become the central assumption of psychiatry, the activities of psychiatrists already largely reflect this viewpoint. As Rennie has said: "The phase of the psychiatrists' exclusive concern with the individual, his biography, and the internal dynamics of his functioning seems ready now to broaden into a concern for people in their community context and the social environment which plays such a large role in the formation of character and in the causation of mental disorders . . ." (28).

To begin with the most immediate milieu of the patient, there has been a rapid development of family treatment, especially with the disturbances of children. It has become standard practice to involve other family members, or even the entire family unit, in the treatment of a disturbed child, and very often the principal treatment is conducted through alterations in the family milieu. Caplan has gone even further and developed the concept of "preventive intervention" during crises of childhood, frequently involving interventions in the family and social surroundings of the child (5). This tendency, long implicit in the child guidance movement, hardly needs documentation, but the point is that it recognizes the active part played by the social surroundings in the illness and health of the individual and implicitly confirms the transactional view of self-development.

The same principle has been widely applied to hospital treatment of disturbed

¹ An even broader view has been described by L. Duhl in *The Urban Condition* (New York: Basic Books, 1963), but it seems likely to me that this represents a conceptual tool useful for mental health program planning, rather than a viewpoint which is apt to become central to psychiatric thought, at least for a good time to come.

persons, as exemplified in the development of the concept of the therapeutic community. The extraordinary alteration in the behavior of patients in response to alteration in the expectations which the community has of them demonstrates the interpenetration of the processes involving the environment and the person (15, 38). The kind of patient who had responded with violence when this had been anticipated by the hospital frequently demonstrated control and co-operation when the expectation of the staff was altered.

An extension of the idea of the hospital as a therapeutic community has been the development of a concept of community psychiatry (6). Essentially this involves a mobilization of the resources of the community to assist its members in maintaining appropriate transactions with itself. This view has been advocated for some time by Querido, who has developed a program of home treatment of psychiatric emergencies by teams of psychiatrists who attempt to deal with the total constellation of patient-environment simultaneously (26). Particularly in schools and universities, the concepts of community psychiatry are being developed and applied to these societies of limited size. There, the psychiatrist often considers the impact of the institutional community on its members, and he may intervene to encourage community efforts to provide opportunities for personal relatedness (3, 36).

Finally, even the practice of individual psychotherapy involves increasing account of the nature of the patient's transactions with his environment. This trend is particularly represented in attention to the communicative transactions of the patient, and in this respect the psychiatrist often regards himself as a representative of the social environment. He may even consider that a major psychotherapeutic func-

tion is to act as a bridge to the establishment of improved communication between the patient and his society; first, by establishing a communicative relationship with himself; then by assisting the patient to re-establish communication with the social and personal environment from which he has become more or less alienated (30).

These activities of the psychiatric subculture all take extensive account of the continuum of interaction between the patient and his social environment. It appears that, operationally at least, psychiatry acts to a considerable extent in terms of a new concept of mental health and illness, even though this is not yet fully articulated by the profession.

It is notable that this second revolution in psychiatric thinking again encompasses the preceding viewpoints in a widened frame of reference. The central focus of psychiatric interest continues to be on the individual, but on the individual in his transactions with his social and physical environment. There is adequate room in this frame of reference to consider the role of disease in disturbing this relationship, and to encompass the role of intrapsychic factors in disturbing the transactions of the individual with his environment.

What seems to be happening is that psychiatry begins to perceive these phenomena in a different way, a way which holds promise of again extending the range and effectiveness of psychiatric activity. For example, it can be shown that the symptoms which accompany such universal biological variables as aging can be "enhanced or muted by the sociocultural variables of living" (25). This new perception opens up the possibility of modifying such symptoms for the better, which is the ultimate purpose of psychiatry.

The fact that practice has outstripped the formulation of this dawning new per-

ception is hardly surprising from the standpoint of transactional psychology. As I have tried to suggest, from this standpoint perceptual assumptions are built from experience. Action, based on some partial grasp of a problem, becomes the basis of a new viewpoint as it succeeds and is validated and confirmed by experience. Nevertheless, as a new way of perceiving a problem is consolidated and becomes an established framework for perception, the new assumptions become a powerful guide for further action.

We can already begin to discern the outlines of the consequences of the transactional viewpoint of mental illness and health. There is certainly increased emphasis on the integration of the person and his community. Rather than removing alienated patients from community contact, attempts are made to diminish the alienation, as in the open hospital, the community treatment center and the emphasis on voluntary admission.

In some programs, still largely experimental but with considerable promise, the principle of integrating the patient with the community has been superseded by an equal effort to integrate the community with the patient. Family treatment, the day hospital, the night hospital, the half-way house and the sheltered workshop are all examples of efforts to alter the community to maintain its relation to the patient. The programs of public education that "the mentally ill can come back" lessen alienation, and we may yet expect to see a campaign based on the idea that the community can prevent mental illness.

A particularly striking example of the application of this viewpoint is the community aftercare program being developed by Jules Coleman. He is mobilizing and integrating many of the resources of the New Haven community in a concerted and

systematic attempt to maintain contact with patients returning from periods of treatment in mental hospitals. Already there have been instances in which these resources have been used before a patient required hospitalization, with some evidence that alienation can be modified when the environment makes efforts to integrate itself with persons who are in danger of alienation.

So it is that we can already see that a new and still partially formulated social perception of mental health and illness is beginning to have operative consequences. It seems quite predictable that, as this viewpoint assumes greater substance and as we become more confident in its application, there will be still further change—most certainly in the development of stronger concepts of community psychiatry.

This developing frame of reference broadens the perspectives of the mental health professions; it does not diminish the necessity for knowledge of the basic disciplines. The modern mental hygienist must be thoroughly familiar with the biologic basis of mental life; he must know the development and dynamics of mental functions; and he must integrate this knowledge within a framework of transactional understanding.

"Every profession has its own subculture, and an important aspect of the latter is a shared system of meanings . . ." as has been pointed out by Caplan (7). I have tried to show how the shared system of meanings of the psychiatric subculture has been undergoing a radical change in the light of new knowledge and experience. This change has come about through the impact of new perceptions on psychiatric thought. Such change does not occur easily, either to the individual or his social group. It is accompanied by periods of confusion, by dislocation of individuals in

relation to the mainstream of the profession, by frequent reversion to previous patterns of perception and by a good deal of personal and social struggle to achieve coherence of the assumptions which guide the activity of the profession.

This is, of course, typical of processes of social change; it therefore seems justified to use the experience of a changing profession as an example of the processes involved. It is certainly more than fortuitous that the new perceptions of psychiatry are of a nature to deal better with the problems raised by changing man in a changing society.

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Mental disease among English-born and native whites of English parentage in New York State, 1949-1951

PART I

Of English Birth

On January 1, 1920, there were 2,786,112 foreign-born whites in New York State, of whom 142,068, or 5.1 per cent, were born in England (including Wales).¹

This was a small total, compared with 529,240 who were born in U.S.S.R., and

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This is the fifth of series of eight studies describing the frequency of mental disease among ethnic and national groups in the United States.

¹ *United States Census of Population, 1950. General Characteristics, New York* (Washington, D. C.: Government Printing Office, 1952), P-B 32, p. 64.

² *Ibid.*

³ *United Nations, Demographic Yearbook* (New York: United Nations, 1957), 636-37.

545,173 who were born in Italy. Other large foreign-born populations came from Germany, Austria and Ireland. On April 1, 1950, the foreign-born white population of New York State totaled 2,500,429, and only 108,875, or 4.4 per cent, were born in England and Wales.²

The decrease of foreign-born, including England, between 1920 and 1950 was due to the restriction of immigration since 1920. Despite their relatively small number, the English-born present a degree of physical and social homogeneity that makes them an important group to study with respect to the incidence of mental disease.

England is not currently the destination of a relatively heavy immigration. And of such immigration, a high proportion is from other parts of the United Kingdom. But for many years prior to the first World War, there had been considerable immigration to England from countries which differed ethnically from the English.

This undoubtedly resulted in racial mixture to some degree. There must have been even more ethnic mingling of this type among foreign-born of English origin, living in New York State. Some support for the latter statement is seen from the fact that whereas practically all first admissions to mental hospitals in New York State from 1949 to 1951 who were Scandinavian-born were classified ethnically as Scandinavian, and almost all of Italian birth were classified ethnically as Italian, only 68 per cent of those born in England were considered as of English ethnic origin. These classifications were made at the hospitals in accordance with definitions in the *Dictionary of Races or Peoples*, prepared for the United States Immigration Commission.⁴

Despite the admixture of different ethnic strains, those born in England have a degree of physical and social homogeneity, arising from a combination of ancestry and a common language, that makes them an important group for study.

We shall therefore examine statistics of first admissions of English-born to all hospitals for mental disease in New York State from October 1, 1948, to September 30, 1951. This period was selected because the mid-point, April 1, 1950, coincided with the date of the census of population, and thus it was possible to compute average annual rates of first admissions.

No comparisons will be made with statistics of first admissions to mental hospitals in England. Such comparisons are not desirable at present, because the degree of hospitalization of mental disease varies throughout the world, for reasons not related to the actual frequency of mental disease. Historical developments determine, in large part, what shall be the statistical levels of admissions to such hospitals.

We should also bear in mind that emi-

gration introduces selective factors with respect to health. Hence, generalizations about English-born, living in New York State, cannot be extended to all of England.

A fundamental prerequisite to the establishment of significant rates of mental disease is the existence of a distribution of the population according to age and sex. Unfortunately, such data were not given separately for English-born in New York State in 1950, but were combined with those for Wales. Therefore, to be consistent, it was necessary to combine first admissions who were born in England or Wales.

Since those born in Wales constituted less than 5 per cent of the population of New York State in 1950 who were born in England and Wales, no substantial error can be introduced in the following analysis. It is to be understood, therefore, that in order to avoid continued repetition of England and Wales, we shall write "born in England," although there will be included a small number of Welsh nativity.

Early census reports include some data as to the incidence of mental disease among foreign-born populations. According to the report on *Insane and Feeble-minded in Hospitals and Institutions*, 1904, "the natives of England and Wales constituted 9 per cent of the foreign-born in the United States in 1900, and were represented by 7 per cent of the foreign-born white insane found in hospitals three years later. In each geographic division the English and Welsh form a larger percentage of the total foreign-born than of all foreign-born white insane."⁵

In 1910, those born in England and Wales constituted 7.2 per cent of the total

⁴ *Dictionary of Races or Peoples*. Report of Immigration Commission. 61st Congress, 3rd Session, U. S. Senate. Document No. 662.

⁵ *Insane and Feeble-minded in Institutions* (Washington, D. C.: Bureau of the Census, 1906), 24.

foreign-born white population in the United States, but only 6.9 per cent of those in hospitals for the insane on January 1, 1910. However, on the basis of total admissions they were slightly in excess of their quota.⁶

In 1922, foreign-born from England and Wales had an annual rate of first admissions of 101.5 per 100,000 population, compared with 113.2 for all white foreign-born.⁷ But the rate for native whites was 56.8. However, these are all crude rates, with no adjustments for such important variables as age and sex proportions. A more thorough investigation is therefore required. We shall consider the necessary data derived from the experience of New York State.

There were 717 first admissions, born in England, to all hospitals for mental disease

⁶ *Insane and Feeble-minded in Institutions* (Washington, D. C.: Bureau of the Census, 1914), 31.

⁷ *Patients in Hospitals for Mental Disease* (Washington, D. C.: Bureau of the Census, 1923), 25.

in New York State during the three years ending September 30, 1951. The leading diagnoses were senile psychoses and psychoses with cerebral arteriosclerosis, with 241 and 221 first admissions, respectively. Together, they included 64.4 per cent of the total first admissions. There were 74 first admissions with involutional psychoses, and only 52 with dementia praecox.

This distribution contrasted sharply with that for native whites in New York State. Among the latter, the senile and arteriosclerotic disorders together represented 25.3 per cent of the total first admissions, whereas dementia praecox represented 3.3 per cent.

The differences were due primarily to the advanced age of the English-born. They had a median age of 55.8 years, compared with 29.0 for native whites living in New York State. Those aged 65 years and over included 31.2 per cent of the English-born, compared with only 6 per cent of the native whites. On the other hand, 6.9 per cent of the native whites were under

TABLE 1

First admissions, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to mental disorders

Mental disorders	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	1	1	2	0.3	0.3	0.3	0.7	0.6	0.6
Alcoholic	22	7	29	6.9	1.8	4.0	15.6	4.0	9.1
With cerebral arteriosclerosis	105	116	221	33.1	29.0	30.8	74.3	66.9	70.1
Senile	89	152	241	28.1	38.0	33.6	63.0	87.7	76.1
Involutional	24	50	74	7.6	12.5	10.3	17.0	28.9	23.5
Manic-depressive	7	8	15	2.2	2.0	2.1	5.0	4.6	4.1
Dementia praecox	17	35	52	5.4	8.8	7.3	12.0	20.2	16.3
Other	52	31	83	16.4	7.8	11.6	36.8	17.9	26.1
Total	317	400	717	100.0	100.0	100.0	224.3	230.8	227.1

40 years of age, compared with only 19.3 per cent of the English-born.

The difference in age affected not only the proportionate distributions of the mental disorders, but also the corresponding rates per 100,000 population. Among English-born, the highest rates were 76.6 for senile psychoses and 70.2 for psychoses with cerebral arteriosclerosis. Other rates in descending order were: involutional psychoses, 23.5; dementia praecox, 16.5; alcoholic psychoses, 9.2; manic-depressive, 4.8. The total rate was 227.9.

The native white population of New York State had an average annual rate of 103.9. The highest rate, 34.3, was for dementia praecox. Other rates were as follows: psychoses with cerebral arteriosclerosis, 15.4; senile psychoses, 10.8; involutional psychoses, 7.9; alcoholic psychoses, 5.8; manic-depressive psychoses, 5.2.

Thus, English-born had lower rates for general paresis, manic-depressive psychoses and dementia praecox, but higher rates for the remaining groups. With respect to the total rate, English-born were in excess in the ratio of 2.19 to 1. The comparisons are all affected, however, by the age distributions of the two populations. The general rate of first admissions rises with age to a maximum at advanced ages. Among the native whites, it rose to a maximum of 705.7 at ages 75 and over. Among English-born, the rate rose to a maximum of 858.1. Since the English-born were older, their crude rate was influenced by the higher proportion at advanced ages. Hence, it is necessary to compare age-specific rates at comparable ages.

These rates were computed directly for native whites from the statistics of first admissions and the corresponding general population. However, the age distribution of the English-born was not available for New York State in 1950, and it was esti-

mated as follows. The ages of the English-born in 1950 are given for the Middle Atlantic division of the United States (New York, New Jersey and Pennsylvania).⁸ There were 189,915 of English birth in this division on April 1, 1950, of whom 104,875, or 55.2 per cent, were living in New York State. Because of this large percentage, we assumed that the English-born in New York State had the same age and sex proportions as those for all English-born in the Middle Atlantic division. The resulting average annual rates of first admissions are shown in Table 2.

There were irregular fluctuations prior to age 40. At subsequent ages, the rates rose to a maximum of 858.1. The sex ratios fluctuated irregularly, but in general, females had higher rates than males up to age 70. Among native whites, females had higher rates up to age 50. Males had higher rates at subsequent ages.

Age-specific rates may be compared for native whites and English-born. For all ages combined, the rate for natives was less than half that for English-born. Yet at many ages, especially among males, native whites had higher rates than English-born. At other ages, the excess of rates for English-born generally did not exceed 20 to 30 per cent. Hence, the higher crude rate of English-born was due to unequal weighting of the age-specific rates.

Adjustment of the rates was made by standardization, using as standard the white population of New York State in the age and sex proportions given by the census of population on April 1, 1950. English-born had a standardized rate of 140.7 per 100,000, compared with 152.0 for native whites. The difference is not statistically signifi-

⁸ *United States Census of Population, 1950, Nativity and Parentage* (Washington, D. C.: Government Printing Office, 1954), Special Reports P-E No. 34, p. 95.

cant, however. English-born males and females each had a lower rate than corresponding native-born. English-born had a significantly lower rate than all foreign-born whites.

It is necessary to give further consideration to a difference that might result from degree of urbanization. It is known that

English-born in the State were living on April 1, 1950.

Standardization of rates for New York City required sets of age-specific rates. These were computed directly for native whites from the data for the general population and for first admissions. But since age data were not available for the English-

TABLE 2

First admissions, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15	..	..	..	..	..	..	..	..	..
15-19	..	..	..	..	..	..	..	..	..
20-24	2	2	4	0.6	0.5	0.6	144.3	28.4	47.4
25-29	2	7	9	0.6	1.8	1.3	51.6	62.7	59.9
30-34	8	7	15	2.5	1.8	2.1	193.8	104.1	138.3
35-39	3	7	10	0.9	1.8	1.4	46.0	84.5	67.5
40-44	6	20	26	1.9	5.0	3.6	49.8	157.9	105.2
45-49	18	22	40	5.7	5.5	5.6	105.2	126.8	116.1
50-54	27	26	53	8.5	6.5	7.4	168.8	153.4	160.9
55-59	20	24	44	6.3	6.0	6.1	138.4	156.8	147.9
60-64	26	35	61	8.2	8.8	8.5	161.2	197.8	180.4
65-69	23	35	58	7.3	8.8	8.1	157.6	177.8	159.3
70-74	52	53	105	16.4	13.3	14.6	423.9	339.4	376.6
75 and over	130	162	292	41.0	40.5	40.7	887.1	836.2	858.1
Total	317	400	717	100.0	100.0	100.0	224.3	230.8	227.9

urban populations have higher rates of mental disease than rural populations. Furthermore, populations living in larger cities have higher rates than those in smaller cities.⁹ Because of differences in classification, a comparison cannot be made on the basis of a complete urban-rural distribution. But an approximation is possible by limiting the comparison to New York City, where more than half of the

born, living in New York City, an approximation was made by assuming that their age proportions were similar to those for English-born in the urban part of the Middle Atlantic division.¹⁰

The standardized rate for English-born in New York City was practically the same as that for the state, but the rate for native whites increased to 168.8. The latter exceeded the rate for English-born by 20 per cent, but the difference was not statistically significant. English-born had a significantly lower rate than all foreign whites.

The data point, therefore, to the possibility that English-born have a low rate of

⁹ Malzberg, Benjamin, "The Distribution of Mental Disease in New York State, 1949-1951," *Psychiatric Quarterly Supplement*, 29(1955), Part 2, p. 216.

¹⁰ See footnote 8, p. 96.

TABLE 3

*Average annual standardized * rates of first admissions to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among English-born †, and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	138.8±11.76	0.88	137.2±10.52	0.97	140.7±7.92	0.93
All foreign-born	168.2± 2.50	1.07	180.5± 2.57	1.27	178.7±1.82	1.18
Native	157.1± 1.35	1.00	141.8± 1.22	1.00	152.0±0.91	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

first admissions with mental disease. This should be checked, when possible, with comparisons based upon larger populations.

Alcoholic Psychoses

There were 29 English-born first admissions with alcoholic psychoses during 1949-

1951, or an average annual rate of 9.2 per 100,000 population. Native whites had a rate of 5.8. As with general paresis, the rates were influenced by the varying proportions of the two populations between ages 35 and 64.

Therefore, further comparisons are

TABLE 4

First admissions with alcoholic psychoses, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 20	..	..	..	..	..	..	..	..	..
20-24	..	..	..	..	..	..	..	..	..
25-29	..	..	..	..	..	..	..	..	..
30-34	..	..	..	..	..	..	..	..	..
35-39	..	1	1	..	14.3	3.5	..	12.1	6.8
40-44	1	2	3	4.6	28.6	10.3	8.3	15.8	12.1
45-49	2	1	3	9.1	14.3	10.3	11.7	5.8	8.7
50-54	9	1	10	40.9	14.3	34.4	56.3	5.9	30.4
55-59	3	1	4	13.6	14.3	13.8	20.8	6.5	13.4
60-64	1	..	1	4.6	..	3.5	6.2	..	3.0
65-69	1	1	2	4.6	14.3	6.9	6.0	5.1	5.4
70-74	2	..	2	9.1	..	6.9	16.3	..	7.2
75 and over	3	..	3	13.6	..	10.3	20.4	..	8.8
Total	22	7	29	100.0	100.0	100.0	15.6	4.0	9.2

shown in Table 5, in which the rates were standardized with respect to age and sex proportions.

The standardized rate for English-born was 7.9 per 100,000 compared with 9.9 for native whites. This resulted from a lower rate among English-born males. English-born females, on the contrary, had a higher rate than native white females. English-born females also had a higher rate than all foreign-born white females.

and tentative. The relatively high rate for English-born females should be stressed, especially in comparison with all foreign-born females.

Psychoses with Cerebral Arteriosclerosis

There were 221 English-born first admissions with psychoses with cerebral arteriosclerosis during 1949-1951, or an average annual rate of 70.2 per 100,000. The cor-

TABLE 5

*Average annual standardized * rates of first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among English-born † and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	11.2±3.36	0.68	5.0±2.01	1.25	7.9±1.88	0.80
All foreign-born	11.7±0.66	0.71	3.4±0.35	0.85	7.4±0.37	0.74
Native	16.4±0.46	1.00	4.0±0.22	1.00	9.9±0.24	1.00

* White population of New York State aged 20 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

The comparisons must be limited still further to New York City, because of the relation of a high degree of urbanization to the incidence of alcoholic psychoses. The standard population was the same as for New York State. We now find that English-born had a higher rate of alcoholic psychoses than all foreign-born whites. But the standardized rate, 10.6, did not differ significantly from that for native whites, 11.3. English-born males had a lower rate than native white males, but English-born females had a higher rate than native white females.

Because of the large probable errors, the differences between the several population groups can only be considered as suggestive

responding rate for native whites was only 15.4. This low rate was due to the fact that the native white population included only 6 per cent at ages 65 and over.

Therefore, comparisons must be limited to populations of comparable age and sex proportions. Standardized rates are shown in Table 7.

It now appears that English-born males had an average annual standardized rate of 61.4 per 100,000, compared with 75.4 for native white males. The rates were equivalent among females. The rate for both sexes combined was 62.4 for English-born and 68.8 for native whites. English-born had lower rates than all foreign-born whites.

TABLE 6

First admissions with psychoses with cerebral arteriosclerosis, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 40	..	..	..	..	..	..	..	..	..
40-44	..	..	..	..	..	..	..	..	..
45-49	..	..	..	..	..	..	..	..	..
50-54	..	1	1	..	0.9	0.4	..	5.9	3.0
55-59	2	3	5	1.9	2.6	2.3	13.8	19.6	16.8
60-64	11	10	21	10.4	8.6	9.5	68.2	56.5	62.1
65-69	12	21	33	11.4	18.1	14.9	71.8	106.7	90.6
70-74	27	30	57	25.7	25.9	25.8	220.1	192.1	204.4
75 and over	53	51	104	50.5	44.0	47.1	361.7	263.2	305.6
Total	105	116	221	100.0	100.0	100.0	74.3	66.9	70.2

As with other groups of mental disorders, concentration in an urban environment influences the relative incidence of psychoses associated with advanced age. As an approximation to degree of urbanization, the rates were standardized for New York City.

On this basis, the difference between English-born and native whites increased. Among males, the average annual standard-

ized rates were 51.1 and 90.7, respectively. Among females, the rate for English-born was only 76 per cent of that for native white females. For both sexes combined, the rates were 54.4 and 83.2, respectively. As for the state as a whole, English-born had lower rates than all foreign-born whites.

Because of the relatively small English-

TABLE 7

*Average annual standardized * rates of first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among English-born † and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	61.4±8.84	0.81	56.8±7.98	1.01	62.4±6.09	0.91
All foreign-born	78.7±1.95	1.04	66.3±1.82	1.18	76.3±1.37	1.11
Native	75.4±0.74	1.00	56.0±1.33	1.00	68.8±1.08	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

TABLE 8

First admissions with senile psychoses, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 50	..	..	..	..	..	..	..	..	..
50-54	..	..	..	..	..	..	..	..	..
55-59	..	2	2	..	1.3	0.8	..	13.1	6.7
60-64	1	10	11	1.1	6.6	4.6	6.2	56.5	32.5
65-69	1	8	9	1.1	5.3	3.7	6.0	40.6	24.7
70-74	16	21	37	18.0	13.8	15.4	130.4	134.4	132.7
75 and over	71	111	182	79.8	73.0	75.5	484.4	572.9	534.8
Total	89	152	241	100.0	100.0	100.0	63.0	87.7	76.6

born population, the differences in rates are not statistically significant. They suggest, however, that English-born had relatively low rates of first admissions with psychoses with cerebral arteriosclerosis.

Senile Psychoses

There were 241 English-born first admissions with senile psychoses during 1949-1951, or an average annual rate of 76.6 per

100,000. Native whites had a corresponding rate of 10.8. As with psychoses with cerebral arteriosclerosis, the low rate for native whites was due to their small proportion at advanced ages. The rates were therefore standardized to adjust for sex and age proportions.

In contrast to psychoses with cerebral arteriosclerosis, English-born had a higher standardized rate of first admissions with senile psychoses than native whites, the

TABLE 9

*Average annual standardized * rates of first admissions with senile psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among English-born † and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	44.8±7.54	1.23	64.9±8.51	1.47	61.2±6.04	1.33
All foreign-born	44.8±1.48	1.23	59.4±1.72	1.34	59.9±1.28	1.30
Native	36.4±1.14	1.00	44.2±1.18	1.00	46.0±0.88	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

rates being 61.2 and 46.0, per 100,000, respectively. There was no significant difference between English-born and all foreign-born whites.

However, further limitation with respect to degree of urbanization shows that there were no significant differences between the several populations. Urbanization was

differences with respect to the frequency of senile psychoses.

Involuntional Psychoses

There were 74 English-born first admissions with involuntional psychoses during 1949-1951, or an average annual rate of

TABLE 10

First admissions with involuntional psychoses, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 30	..	..	..	..	..	..	..	..	..
30-34	..	..	..	..	..	..	..	..	..
35-39	..	1	1	..	2.0	1.4	..	12.1	6.8
40-44	..	6	6	..	12.0	8.1	..	47.4	24.3
45-49	1	9	10	4.2	18.0	13.5	5.8	51.9	29.0
50-54	8	13	21	33.3	26.0	28.4	50.0	76.7	63.7
55-59	4	10	14	16.7	20.0	18.9	27.7	65.3	47.1
60-64	8	8	16	33.3	16.0	21.6	49.6	45.2	47.3
65-69	3	2	5	12.5	4.0	6.8	17.9	10.2	13.7
70-74	..	1	1	..	2.0	1.4	..	6.4	3.6
75 and over	..	..	..	..	..	..	..	..	..
Total	24	50	74	100.0	100.0	100.0	17.0	28.9	23.5

held approximately constant by limiting comparisons to New York City.

On this basis, English-born had a standardized rate of 63.0 per 100,000 in New York City, compared with 63.1 for all foreign-born whites, and 64.9 for native whites. English-born males had a lower rate than the others. English-born females had a higher rate. But in neither case were the differences significant.

We conclude that for constant age and sex proportions and an approximately constant environment, there were no significant

23.5 per 100,000. Native whites had a rate of 7.9.

However, we must consider the effect of the different age and sex proportions of the two populations. The rates were therefore standardized and are summarized in Table 11.

The standardized rates were 29.2 and 21.4 per 100,000 for English-born and native whites, respectively. The former was in excess by 36 per cent. English-born males and females both had higher rates than native-born, the excess being greater

among females. English-born and all foreign-born whites had equivalent rates.

Limiting the comparisons still further to New York City, we find standardized rates of 32.3 and 24.6 for English-born and native whites, respectively, the excess of the former amounting to 31 per cent. There were differences with respect to sex, however. English-born males had a lower rate than native white males. But the rate for English-born females was in excess by 50

ing rate of 34.3. The difference was due, in part, to the fact that native whites had a significantly higher proportion under age 40.

Therefore, the rates were standardized with respect to age and sex distributions. (See Table 13)

When standardized, the rates became 26.6 per 100,000 for English-born and 41.3 for native whites. The latter was in excess by 55 per cent. English-born also had a sig-

TABLE 11

*Average annual standardized * rates of first admissions with involutional psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among English-born † and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	17.7±4.38	1.23	41.4±6.29	1.43	29.2±3.84	1.36
All foreign-born	17.9±0.86	1.24	42.0±1.31	1.44	29.5±0.78	1.38
Native	14.4±0.56	1.00	29.0±0.74	1.00	21.4±0.47	1.00

* White population of New York State aged 35 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

per cent. In comparison with all foreign-born whites, English-born males had a lower rate, and English-born females had a higher rate.

When factors of sex, age, and size of population are considered, it appears that the rates of first admissions with involutional psychoses did not differ significantly among English-born and all foreign-born whites. Both, however, had higher rates than native whites.

Dementia Praecox

There were 52 English-born first admissions with dementia praecox during 1949-1951, or an average annual rate of 16.5 per 100,000. Native whites had a correspond-

nificantly lower rate than all foreign-born whites. There was no significant sex difference in rates among English-born and native whites. Among all foreign-born whites, however, males had a higher rate.

A further adjustment was introduced by limiting the rates to New York City. The relative difference was increased by considering size of population. Thus, the standardized rate of native whites was in excess by 55 per cent in New York State, but was in excess by 79 per cent in New York City. The standardized rates for New York City were 27.3 and 48.9 for English-born and native whites, respectively. English-born males and females had lower rates than the corresponding sexes among the foreign-born and

TABLE 12

First admissions with dementia praecox, born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	..	..	..	..	..	..	..	..	..
10-14	..	..	..	..	..	..	..	..	..
15-19	..	..	..	..	..	..	..	..	..
20-24	1	2	3	5.9	5.7	5.8	72.2	28.4	35.5
25-29	2	5	7	11.8	14.3	13.4	51.6	44.8	46.6
30-34	4	2	6	23.5	5.7	11.5	96.9	29.7	55.3
35-39	..	2	2	..	5.7	3.8	..	24.1	13.5
40-44	2	6	8	11.8	17.1	15.4	16.6	47.4	32.4
45-49	2	6	8	11.8	17.1	15.4	11.7	34.6	23.2
50-54	4	6	10	23.5	17.1	19.2	25.0	35.4	30.4
55-59	1	4	5	5.9	11.4	9.6	6.9	26.1	16.8
60-64	1	2	3	5.9	5.7	5.8	6.2	11.3	8.9
65-69	..	..	..	..	..	..	..	..	..
70-74	..	..	..	..	..	..	..	..	..
75 and over	..	..	..	..	..	..	..	..	..
Total	17	35	52	100.0	100.0	100.0	12.0	20.2	16.5

native white populations. Contrary to the state as a whole, English-born females had a higher rate than English-born males in New York City.

It appears, then, that when such factors

as age, sex and environment are kept constant, English-born in New York had a lower rate of first admissions with dementia praecox than all foreign-born and native-born whites.

TABLE 13

*Average annual standardized * rates of first admissions with dementia praecox to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951 among English-born † and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	27.3±5.22	0.65	26.3±4.61	0.64	26.6±3.44	0.64
All foreign-born	57.2±1.46	1.37	50.3±1.36	1.24	52.7±0.99	1.28
Native	41.8±0.70	1.00	40.6±0.65	1.00	41.3±0.48	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

PART II

Of English Parentage

On January 1, 1920, there were in New York State 205,988 native whites whose parents were born in either England or Wales, over 90 per cent having been born in England.¹¹ Native whites of English parentage are defined as those with English-born parents, or of mixed parentage, of whom one parent was English-born.

On April 1, 1950, there were 198,895 native whites with such parentage in New York State.¹² It is evident, therefore, that the English, whether native or foreign-born, are a declining stock in New York State.

What is the incidence of mental disease among second-generation of English origin in New York State, and how does it compare with the incidence among English-born?

Since there is some mingling with non-English stock among the two generations,

¹¹ *Fourteenth Census of the United States, Vol. II, Population, 1920* (Washington, D. C.: Government Printing Office, 1922), 913.

¹² See footnote 8, p. 77.

differences in rates of first admissions might be attributed in part to differences in ethnic composition. However, there is still a predominance of English by ethnic origin. Therefore, it is probable that the levels of mental disease in the two generations will differ largely because of environmental factors.

There were 918 first admissions among native whites of English parentage to all hospitals for mental disease in New York State during 1949-1951. Of this total, 233, or 25.4 per cent, were diagnosed as psychoses with cerebral arteriosclerosis, and 166, or 18.1 per cent, as senile psychoses. Together, they included 43.5 per cent of the total. Dementia praecox included 191 cases, or 20.8 per cent. Among English-born, the two disorders associated with advanced age included 64.4 per cent of the total, and dementia praecox included only 7.3 per cent.

The average annual crude rate for natives of English parentage was 153.9 per 100,000, compared with 227.9 for English-born. For psychoses with cerebral arterio-

TABLE 14

Native white first admissions, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to mental disorders

<i>Mental disorders</i>	<i>Number</i>			<i>Per cent</i>			<i>Average annual rate per 100,000 population</i>		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	4	4	8	0.9	0.8	0.9	1.4	1.3	1.3
Alcoholic psychoses	35	13	48	8.3	2.6	5.2	12.6	4.1	8.0
Psychoses with cerebral arteriosclerosis	104	129	233	24.6	26.1	25.4	37.3	40.6	39.0
Senile	60	106	166	14.2	21.4	18.1	21.5	33.3	27.8
Involuntional	28	57	85	6.6	11.5	9.3	10.0	17.9	14.2
Manic-depressive	10	13	23	2.4	2.6	2.5	3.6	4.1	3.9
Dementia praecox	91	100	191	21.5	20.2	20.8	32.6	31.4	32.0
Other	91	73	164	21.5	14.7	17.9	32.6	23.0	27.5
Total	423	495	918	100.0	100.0	100.0	151.7	155.7	153.9

TABLE 15

Native white first admissions, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	3	..	3	0.7	..	0.3	13.1	..	6.7
10-14	1	2	3	0.2	0.4	0.3	9.3	19.7	14.4
15-19	12	10	22	2.8	2.0	2.4	95.2	77.6	86.3
20-24	36	16	52	8.5	3.2	5.7	234.4	95.8	162.2
25-29	21	19	40	5.0	3.8	4.4	123.0	101.9	112.0
30-34	19	19	38	4.5	3.8	4.1	97.2	88.4	92.6
35-39	23	34	57	5.4	6.9	6.2	102.0	130.3	117.2
40-44	28	33	61	6.6	6.7	6.6	110.0	115.1	112.7
45-49	27	45	72	6.4	9.1	7.8	103.0	155.0	130.3
50-54	29	44	73	6.9	8.9	8.0	106.6	144.9	126.8
55-59	36	31	67	8.5	6.3	7.3	141.0	110.1	124.8
60-64	36	21	57	8.5	4.2	6.2	190.9	92.3	137.0
65-69	38	35	73	9.0	7.1	8.0	275.1	184.6	222.8
70-74	28	47	75	6.6	9.5	8.2	282.8	323.9	307.2
75 and over	86	139	225	20.3	28.1	24.5	771.6	788.5	782.0
Total	423	495	918	100.0	100.0	100.0	151.7	155.7	153.9

sclerosis, the corresponding rates were 39.0 and 70.2, respectively. For senile psychoses, they were 27.8 and 76.6, respectively. For dementia praecox, however, the rates were 32.0 and 16.5, respectively. Obviously, the lower rates for the native-born with respect to disorders of advanced age, and their higher rate for dementia praecox were consequences of the different age distributions of the two populations.

The crude rates were therefore revised by adjustment to a common standard. The white population of New York State, as of April 1, 1950, in appropriate age intervals, was used as standard. The computation of age-specific rates for English-born was explained in a previous section.

The age classification of native-born whites of English parentage was not given for New York State. It was therefore assumed to be the same as the percentage

distribution for native whites of English parentage living in the Middle Atlantic Division of the United States on April 1, 1950.¹³ Age-specific rates were obtained by relating first admissions to the derived age distribution of the native whites of English parentage. Resulting standardized rates are shown in Table 16.

Natives of English parentage had a standardized average annual rate of 157.3 per 100,000, compared with 123.2 for native whites of native parentage. Native males and females of English parentage had higher rates than the corresponding natives of native parentage. Natives of English origin also had a higher rate than English-born. But they had a lower rate than all native whites of foreign parentage.

A further adjustment must be made with

¹³ *Ibid.*, p. 95.

respect to environment (urban vs. rural). For reasons given previously, such an adjustment must be approximated by limiting the comparison to New York City. The age distribution of native whites of English parentage in New York City was obtained by assuming that it was similar to the distribution for natives of English parentage living in the urbanized part of the Middle Atlantic division of the United States on April 1, 1950.¹⁴

Alcoholic Psychoses

There were 48 first admissions with alcoholic psychoses during 1949-1951 among native whites of English parentage, or an average annual rate of 8.0 per 100,000 population. English-born had a corresponding rate of 9.2. These rates were affected in varying degree by differences in age and sex proportions of the two populations.

Therefore, rates standardized with respect to age and sex are given in Table 18.

TABLE 16

*Average annual standardized * rates of first admissions to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of English parentage † and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	158.9±9.40	1.25	142.3±8.24	1.22	157.3±6.35	1.28
All foreign-born	201.9±2.28	1.59	177.0±2.03	1.52	197.8±1.56	1.61
Native	126.9±1.64	1.00	116.3±1.49	1.00	123.2±1.11	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

We find, again, that natives of English parentage had a higher standardized rate than native whites of native parentage. They had a lower rate than all natives of foreign parentage. But they had a higher rate than English-born.

Thus, contrary to the trend shown by other populations, the second generation of English stock in New York State had a higher rate of first admissions than English-born. They also had a higher rate than natives of native parentage. But they had a lower rate than all natives of foreign parentage.

We now find a slight excess among natives of English parentage. They had a standardized rate of 8.8 per 100,000, compared with 7.9 for English-born. This was due to an excess on the part of native males of English parentage. Natives of English parentage had a lower rate than all native whites of foreign parentage. But they exceeded slightly the rate for natives of native parentage. This was due to an excess among native females of English parentage.

Because of the relation of alcoholic psychoses to degree of urbanization, a further comparison was limited to New York City.

¹⁴ *Ibid*, p. 96.

TABLE 17

Native white first admissions with alcoholic psychoses, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 20	..	..	..	..	..	..	..	..	..
20-24	..	..	..	..	..	..	..	..	..
25-29	..	..	..	..	..	..	..	..	..
30-34	2	2	4	5.7	15.4	8.3	10.2	9.3	9.7
35-39	1	3	4	2.9	23.1	8.3	4.4	11.5	8.2
40-44	3	..	3	8.6	..	6.3	11.8	..	5.5
45-49	10	3	13	28.6	23.1	27.1	38.1	10.3	23.5
50-54	6	2	8	17.1	15.4	16.7	22.1	6.6	13.9
55-59	7	1	8	20.0	7.7	16.7	27.4	3.6	14.9
60-64	3	1	4	8.6	7.7	8.3	15.9	4.4	9.6
65-69	3	..	3	8.6	..	6.3	21.7	..	9.8
70-74	..	..	..	..	..	..	..	..	..
75 and over	..	1	1	..	7.7	2.1	..	5.7	3.4
Total	35	13	48	100.0	100.0	100.0	12.6	4.1	8.0

Native whites of English parentage had a standardized rate of 10.6, the same as for English-born. But there were small differences with respect to sex. Native males of English parentage had a higher rate than English-born males, but native females of

English parentage had a lower rate. The reverse order of differences occurred in comparison with all natives of foreign parentage. Compared to natives of native parentage, those of English parentage had a small, but not significant, excess.

TABLE 18

*Average annual standardized * rates of first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of English parentage † and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England	13.3±2.79	0.96	4.7±1.54	1.34	8.8±1.54	1.04
Native	19.9±0.74	1.43	4.6±0.34	1.31	11.9±0.40	1.42
All foreign-born	13.9±0.58	1.00	3.5±0.28	1.00	8.4±0.31	1.00

* White population of New York State aged 20 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

TABLE 19

Native white first admissions with psychoses with cerebral arteriosclerosis, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 40	..	..	..	..	..	..	..	..	..
40-44	..	..	..	..	..	..	..	..	..
45-49	..	..	..	..	..	..	..	..	..
50-54	..	3	3	..	2.3	1.3	..	9.9	5.2
55-59	7	9	16	6.7	7.0	6.9	27.4	32.0	29.8
60-64	16	9	25	15.4	7.0	10.7	84.8	39.6	60.1
65-69	24	25	49	23.1	19.4	21.0	173.7	131.9	149.5
70-74	16	27	43	15.4	20.9	18.4	161.6	186.1	176.2
75 and over	41	56	97	39.4	43.4	41.6	367.9	317.7	337.1
Total	104	129	233	100.0	100.0	100.0	37.3	40.6	39.0

Psychoses with Cerebral Arteriosclerosis

There were 233 first admissions with psychoses with cerebral arteriosclerosis among native whites of English parentage, or an average annual rate of 39.0 per 100,000, compared with 70.2 for English-born.

The difference was due to the larger proportion of aged among the foreign-born.

Table 20 shows standardized rates of first admissions in which adjustments were made for differences in age and sex proportions.

Natives of English parentage had a standardized rate of 72.4 per 100,000, compared with 62.4 for English-born, thus reversing the order based upon crude rates. Males and females each had a higher rate than

TABLE 20

*Average annual standardized * rates of first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of English parentage † and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	73.7±8.71	1.32	63.4±7.33	1.75	72.4±5.80	1.52
All foreign-born	108.4±3.06	1.94	85.4±2.51	2.36	102.0±2.01	2.14
Native	55.7±1.86	1.00	36.2±1.41	1.00	47.6±1.18	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

those for corresponding groups of English-born. Natives of English parentage had a lower rate than all natives of foreign parentage. But they had a significantly higher rate than natives of native parentage.

When comparisons were limited to New York City in order to adjust for differences in degree of urbanization, we found the following: Natives of English parentage had a standardized rate of 54.2 per 100,000, compared with 54.4 for English-born. There

born had a corresponding rate of 76.6. The difference was obviously related to the greater proportion of aged among the English-born.

It was therefore necessary to standardize the rates. The results are shown in Table 22.

Native-born of English parentage had a standardized rate of 47.6 per 100,000, compared with 61.2 for English-born. Both exceeded the rate for natives of native par-

TABLE 21

Native white first admissions with senile psychoses, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 50	..	..	..	..	..	..	..	..	..
50-54	..	..	..	..	..	..	..	..	..
55-59	..	..	..	..	..	..	..	..	..
60-64	..	..	..	..	..	..	..	..	..
65-69	6	6	12	10.0	5.7	7.2	43.4	31.7	36.6
70-74	9	19	28	15.0	17.9	16.9	90.9	130.9	114.7
75 and over	45	81	126	75.0	76.4	75.9	403.8	459.5	437.9
Total	60	106	166	100.0	100.0	100.0	21.5	33.3	27.8

were sex differences, however, native males of English parentage having a lower rate, females a higher rate. Natives of English parentage had a lower rate than all natives of foreign parentage, but a higher rate than natives of native parentage. In the latter comparison, native males of English parentage had a lower rate than native males of native parentage, but the order was reversed for females.

Senile Psychoses

There were 166 first admissions with senile psychoses among native-born of English parentage during 1949-1951, or an average annual rate of 27.8 per 100,000. English-

parentage. Both generations of English origin had lower standardized rates of senile psychoses than all native-born of foreign parentage.

A further comparison was made by limiting the rates to the respective populations living in New York City. Native-born of English parentage had a standardized rate in New York City of 53.8, compared with 63.0 for English-born. The former exceeded the rate for native-born of native parentage. As for the entire State, the two generations of English origin, living in New York City, had lower rates of first admissions with senile psychoses than all natives of foreign parentage.

Thus, when age and sex variables are held

TABLE 22

*Average annual standardized * rates of first admissions with senile psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of English parentage † and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	39.4±6.39	1.66	44.9±6.16	1.49	47.6±4.69	1.57
Native	58.1±2.24	2.45	67.8±2.23	2.24	70.6±1.67	2.32
All foreign-born	23.7±1.21	1.00	30.2±1.29	1.00	30.4±0.94	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

constant in an urban environment, it appears that native whites of English parentage had a lower rate of senile psychoses than English-born, but a higher rate than native whites of native parentage. Because of the large probable errors, these differences must be substantiated by further investigations.

Involucional Psychoses

There were 85 native first admissions of English parentage, with involucional psychoses, during 1949-1951, or an annual average of 14.2 per 100,000 population. The corresponding rate for English-born was 23.5.

TABLE 23

Native white first admissions with involucional psychoses, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 30	..	..	..	..	..	..	..	..	..
30-34	..	..	..	..	..	..	..	..	..
35-39	..	..	..	..	..	..	..	..	..
40-44	..	9	9	..	..	..	..	..	..
45-49	1	15	16	..	15.8	10.6	..	31.4	16.6
50-54	7	16	23	3.6	26.3	18.8	3.8	51.7	29.0
55-59	11	10	21	25.0	28.1	27.1	25.7	52.7	39.9
60-64	6	6	12	39.3	17.5	24.7	43.1	35.5	39.1
65-69	2	1	3	21.4	10.5	14.1	31.8	26.4	28.8
70-74	1	..	1	7.1	1.8	3.5	14.4	5.3	9.2
75 and over	..	..	..	3.6	..	1.2	10.1	..	4.1
Total	28	57	85	..	..	..	..	..	..
	28	57	85	100.0	100.0	100.0	10.0	17.9	14.2

As with other groups of mental disorders, the crude rates were influenced by the varying age and sex proportions of the populations. Rates standardized for such variations are therefore shown in Table 24.

Natives of English parentage had a standardized rate of 20.4 per 100,000, compared with 29.2 for English-born. The former also had a lower rate than all natives of foreign parentage. However, they had a higher rate than natives of native parentage by 25 per cent.

Dementia Praecox

There were 191 first admissions with dementia praecox during 1949-1951 from among the native-born population of English parentage, or an average annual rate of 32.0 per 100,000 population. English-born had a corresponding rate of 16.5.

The higher proportion of English-born at advanced ages, beyond the usual range for this disorder, would tend to reduce their crude rate for dementia praecox. Hence,

TABLE 24

*Average annual standardized * rates of first admissions with involutional psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of English parentage † and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	14.2±3.28	1.31	27.4±4.16	1.23	20.4±2.65	1.25
All foreign-born	20.0±0.98	1.85	37.6±1.26	1.69	28.4±0.80	1.74
Native	10.8±0.66	1.00	22.3±0.89	1.00	16.3±0.55	1.00

* White population of New York State aged 35 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

We shall approximate a further difference with respect to environment (urban-rural), by limiting the comparison to New York City. We then find a standardized rate of 23.6 per 100,000 for natives of English parentage, compared with 32.3 for English-born. The former had a lower rate than all native-born of foreign parentage, but a higher rate than natives of native parentage.

There is a suggestion, therefore, of differences in the relative frequency of involutional psychoses among the several nativity groups, but this must be supported by further investigations.

the rates were standardized with respect to age and sex proportions. (See Table 26).

Native-born of English parentage had a standardized rate of 44.6 per 100,000, compared with 26.6 for English-born. Hence, it is clear that the second generation had a higher rate. Both generations had lower rates than all native-born of foreign parentage. However, though English-born had a lower rate than natives of native parentage, second-generation English had a higher rate.

Dementia praecox is more frequent in urban areas and is especially high in New York City. Hence, the rates were standard-

TABLE 25

Native white first admissions with dementia praecox, parents born in England and Wales, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	1	..	1	1.1	..	0.5	4.4	..	2.2
10-14	1	1	2	1.1	1.0	1.0	9.3	9.8	9.3
15-19	7	5	12	7.7	5.0	6.3	55.6	38.8	47.1
20-24	22	10	32	24.2	10.0	16.8	143.2	59.9	99.8
25-29	16	14	30	17.6	14.0	15.7	93.7	75.1	84.0
30-34	11	11	22	12.1	11.0	11.5	56.3	51.2	53.6
35-39	12	21	33	13.2	21.0	17.3	53.2	80.5	67.8
40-44	10	14	24	11.0	14.0	12.6	39.3	48.8	44.3
45-49	6	13	19	6.6	13.0	10.0	22.9	44.8	34.4
50-54	2	7	9	2.2	7.0	4.7	7.4	23.0	15.6
55-59	2	..	2	2.2	..	1.0	7.8	..	3.7
60-64	1	3	4	1.1	3.0	2.1	5.3	13.2	9.6
65-69	..	..	..	..	..	..	..	..	..
70-74	..	..	..	..	..	..	..	..	..
75 and over	..	1	1	..	1.0	0.5	..	5.7	3.4
Total	91	100	191	100.0	100.0	100.0	32.6	31.4	32.0

ized still further with reference to New York City.

Native-born of English parentage had a standardized rate of 59.9 per 100,000, compared with 27.3 for English-born. The

former also had higher rates than natives of native parentage, whereas English-born had a lower rate.

Thus, there was an increase in the relative frequency of dementia praecox among

TABLE 26

*Average annual standardized * rates of first admissions with dementia praecox to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of English parentage † and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
England †	45.5±5.03	1.38	41.4±4.47	1.26	44.6±3.39	1.35
All foreign-born	52.4±1.16	1.59	49.7±1.08	1.51	52.4±0.80	1.59
Native	32.9±0.83	1.00	32.9±0.80	1.00	33.0±0.58	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

† Includes Wales.

native-born of English parentage, so that the latter exceeded not only the native-born of native parentage, but also all natives of foreign parentage.

SUMMARY

There were 717 English-born first admissions to all hospitals for mental disease in New York State during the three years ending September 30, 1951. Almost two-thirds were diagnosed as either senile psychoses or psychoses with cerebral arteriosclerosis. Less than 10 per cent were diagnosed as dementia praecox. This differs widely from the distribution for native-born whites. Among the latter, the two disorders associated with advanced age included only 25.3 per cent of the total first admissions, but dementia praecox included 33.0 per cent.

Average annual rates of first admissions differed in the same way. Thus, English-born had a rate of 76.6 per 100,000 for senile psychoses and 70.2 for psychoses with cerebral arteriosclerosis. The corresponding rates for native whites were 10.8 and 15.4, respectively. With respect to dementia praecox, the rates were 16.5 and 34.3 for English-born and native whites, respectively.

The differences in crude rates were due primarily to the age distributions of the two populations, the English-born being concentrated at older ages. It was therefore necessary to standardize the rates with respect to age. On this basis, English-born had an average annual rate of 140.7 per 100,000, compared with 152.0 for native whites. Thus, instead of being in excess by 119 per cent, as implied by crude rates, the rate for English-born represented only 93 per cent of that for native whites, when corrected for age differentials. In New York City, the ratio was reduced still further to 84 per cent. Thus, whereas the rate for all foreign-born whites exceeded that of native

whites by almost 10 per cent, English-born showed a low rate of first admissions.

Because of the relatively small number of English-born in New York State, the standardized rates had large probable errors, and the differences in rates therefore were not statistically significant. Significance must be attached, however, to the fact that the differences arising in the major groups of psychoses point in the same direction.

Thus, English-born had lower standardized rates of first admissions than native whites with respect to general paresis, alcoholic psychoses, psychoses with cerebral arteriosclerosis, and manic-depressive psychoses. The difference was notable in the case of dementia praecox, the standardized rate for English-born living in New York City representing less than 60 per cent of that for native whites. Only for involutional psychoses did the English-born have a higher rate. The English-born had lower rates than all foreign-born in all major groups with the exception of the alcoholic psychoses.

There were 918 natives of English parentage who were first admissions to hospitals for mental disease in New York State during 1949-1951. Because they were younger than English-born, they had lower rates of first admissions with psychoses of advanced age, but a higher rate of dementia praecox. But they were also older than all native whites of native parentage, and therefore had a higher rate of psychoses of advanced age. Because of these differences in age, deductions from crude rates are misleading. Thus, natives of English parentage had a total crude rate of first admissions of 153.9 per 100,000, compared with 77.2 for natives of native parentage, an excess of 99 per cent. On the basis of standardized rates, the excess was reduced to 30 per cent, but this difference was significant.

It must be recognized that natives of Eng-

lish parentage were of the second-generation of such stock in New York State, whereas natives of native parentage included unknown proportions of third and older generations. It is therefore possible that comparisons of those of the same generation might introduce corrective factors. However, the necessary data are lacking with respect to natives of native parentage.

This excess was repeated in comparisons of standardized rates for all major psychoses, except manic-depressive.

Natives of English parentage had a lower standardized rate than all natives of foreign parentage. But there were two important exceptions to this in New York City; namely, general paresis and dementia praecox.

We come, finally, to the contrast between English-born and natives of English parentage. Generally, it is found that the second-generation of whites of foreign parentage in New York State has a lower rate of mental disease than the older generation of foreign-

born. The English depart significantly from this trend. With adjustments for sex, age and size of population, we find an overall standardized rate of 163.7 per 100,000 for natives of English parentage, and 141.1 for English-born. With respect to dementia praecox, the rates were 59.9 and 27.3, respectively. Only with respect to senile psychoses and involutional psychoses did natives of English parentage have lower rates. The rates were equivalent for alcoholic psychoses and psychoses with cerebral arteriosclerosis.

With the data at hand we can only speculate as to reasons for this reversal of the generations with respect to relative frequency of mental disease. It is possible that the English-born underwent a favorable selection before emigrating. This might have been self-selection, the healthier and more vigorous being more likely to emigrate. Selection may also have been exercised by American authorities at places of origin of the migrating stream.

Psychiatry in a midwestern metropolitan community

The subjects for this study were a group of psychiatrists practicing in a midwestern metropolitan community. They were located in the greater Twin City area of Minnesota which included Minneapolis, St. Paul, and the adjacent suburbs.

Data was obtained with respect to the following major categories: theoretical orientations regarding psychiatry, professional training, conditions of work, income, psychosocial and family data, political affiliation, and views on payment for psychiatric treatment. The method of investigation used was that of an inventory or survey. The data are subject to numerous interpretations, which vary from the naive to those attempting profound "depth" explanations. As far as possible the author has avoided high-level theoretical explanation. Rather, he has adhered to empirical, probabilistic generalizations when indicated.

MATERIAL AND METHODS

In this study a mimeographed form letter and answer sheet were sent to the 72 members of the American Psychiatric Association, living in the Twin City area suburbs, who were listed in the official publication of the APA for 1960.¹ This made up 55 per cent of the total number of 131 psychiatrists listed in the entire state of Minnesota. The letter which accompanied the questionnaire specified that complete anonymity was desired and that no follow-up form would be sent out.

The definition which was arbitrarily adopted for a "psychiatrist" in this paper is thus evident; i.e., a member of the Amer-

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¹ American Psychiatric Association, *The 1959-1960 List of Fellows and Members of the American Psychiatric Association* (Washington, D.C.: American Psychiatric Association, 1960).

ican Psychiatric Association. The standards for admission to this organization are set at one-year of psychiatric residency or training in a mental hospital, or its equivalent.²

Obviously, the definition as used here does not include all the physicians in the area who are practicing psychiatry. It is estimated that of the 13,000 physicians in this country devoting their full time to the practice of psychiatry, 10,500 are members of the American Psychiatric Association, 2,000 to 3,000 are in psychiatric residency programs, and about 1,000-2,000 are not members of the Association.³

Even more broadly, no attempt has been made to establish the unknown numbers of people in related professions doing "psychotherapy," such as psychologists, counselors and clergymen, etc. Of the 72 members of the A.P.A., 55 (76 per cent) were board-certified specialists who had passed the specialty requirements of the American Board of Psychiatry and Neurology. Three were certified solely in neurology and eight in psychiatry and neurology. This left 17 members of the American Psychiatric Association in this area who had not passed or taken the certifying examination of the Board.

Sixty-one replies were obtained from the seventy-two forms sent out to the members. One of these was from a member's widow, indicating his death since the last listing

of the Twin City psychiatrists, and this completed form was not used. The completed forms were thus returned by 85 per cent of the members of the American Psychiatric Association in the greater Minneapolis-St. Paul area. This excellent response was gratifying and probably was due to the combination of complete anonymity in the survey, coupled with the interest of the participants, since the data would later be made available to them.

The basic division of psychiatrists was based on the type of therapy predominantly practiced and the training for therapy the practitioners had received. While Hollingshead and Redlich were able to get a more distinct classification into two groups in their New Haven study, those having an analytic and psychological orientation (*the A-P group*), and those having a directive and organic approach (*the D-O group*), a preliminary survey among psychiatrists in the Twin City area indicated the lack of such a distinct delineation.⁴ Hence, a breakdown was made into three groups, primarily based on the following question:

Would you describe most of your treatment as predominantly:

- (1) Organic treatment (EST, drugs, etc.).
- (2) Organic treatment plus brief, psychotherapy (up to 20 visits).
- (3) Psychotherapy—supportive and/or brief re-educative therapy (non-psychoanalytic).
- (4) Psychoanalytically-oriented therapy.
- (5) Psychoanalysis.

Those answering (1) or (2) were regarded as members of the D-O group while those answering (4) or (5) would be part of the A-P group. The middle category delineated a third group, which actually has more affinity with the D-O group, but is distinguished by doing longer-term therapy, such as re-educative therapy of over 20 visits. For practical purposes this group

² American Psychiatric Association, *Biographical Directory of Fellows and Members of the American Psychiatric Association* (New York: R. R. Bowker Co., 1958).

³ Blain D., "The Organization of Psychiatry in the United States," in Arletti, Silvano, ed., *American Handbook of Psychiatry, Vol. II* (New York: Basic Books, Inc., 1959), 1, 960-82.

⁴ Hollingshead, A. B. and F. C. Redlich, *Social Class and Mental Illness: A Community Study* (New York: John Wiley & Sons, Inc., 1958), 155.

(the S-R group) can usually be grouped with the D-O's.

It must be pointed out that the usage here of the A-P grouping implies a somewhat different type of practice than it did in the New Haven study. This will become apparent as more material is presented, but to illustrate this, not one of the 60 physicians replying indicated their practice was predominantly "psychoanalysis," and of those checking "psychoanalytically-oriented therapy," some of the respondents had never been analyzed.

Thus, this survey indicated that a certain number of those checking the latter response were attempting, with the best of their ability and with the limited training they had obtained, to apply psychoanalytic techniques in their practice. The specific psychoanalytic orientation toward which they might be adhering was not elicited. This contrasts with what Hollingshead and Redlich included in their A-P group, which encompassed "those psychiatrists who are fully trained psychoanalysts, among them some of the leaders in the field, as well as those who have had some psychoanalytic orientation in their residency training for instance, or therapeutic experience by way of their own psychoanalysis or intensive psychotherapy."⁵

The A-P group is also essentially non-directive in its psychotherapeutic approach and utilizes a psychodynamic explanatory model for behavior. There are basic concepts and assumptions which tend to have almost universal acceptance within this group, such as an emphasis upon unconscious processes, the purposive or motivational quality of behavior, the significance of defense mechanisms, and the crucial importance of childhood with respect to later symptom and character formation.

Other psychoanalytic concepts were less

universally accepted, such as the relative significance of sexual factors, the hedonistic basis for motivation, various tenets of instinct theory, and the importance of interpersonal relations in development and pathology. Suffice it to say that these concepts are often regarded as verbal gymnastics or the unwarranted intrusion of philosophy into science by the D-O group. The attitude of the A-P group is often that of superiority toward the "pill-pushers."

Even adopting the above mentioned grouping, despite its dissimilarity from the New Haven study, we found only 18 of the 60 respondents being classified in the A-P group (30 per cent). Twenty-four were in the D-O group and 18 in the S-R group (70 per cent total). In the survey of 40 psychiatrists in private, university, and state hospital practice, administering psychiatric care to the New Haven population, 60 per cent were found to be in the A-P group and 40 per cent in the D-O category.⁶

The two basic groups may be further contrasted. The preponderant D-O group in the Twin City administers mainly shock treatment and drug therapy. Brief forms of psychotherapy may be used; these usually take the form of brief follow-ups to make sure the shock treatment or drugs have "worked."

The D-O type of psychotherapy often involves guidance and advice giving ("When I'm done with the day's therapy, I'm hoarse"), and environmental manipulation by attempting to change the conditions at work or home and thus secure a change in the patient's attitudes and interests. The directive element is quite prominent and

⁵ *Ibid.*, p. 157.

⁶ Maciver, J. and F. C. Redlich, "Patterns of Psychiatric Practice," *American Journal of Psychiatry* 115(February, 1959), 692-97.

is seen in suggestions with the full weight and prestige of the physician-psychiatrist regarding decisions, frequently coupled with persuasive arguments to back up these suggestions.

The D-O group is thus composed of a continuum from those relying almost completely on organic treatment to those attempting environmental manipulation. This group is frequently outspokenly hostile and critical of the "mysticism" of the psychoanalytic approaches.

The fundamental distinction between the groups composed of the D-O's and S-R's from the A-P therapists would appear to be the relative emphasis on directive techniques in the former over the latter, and also the stress on conscious and current processes in treatment as contrasted with the working-through type of treatment that involves analyzing unconscious motivations and relationships for the A-P group.

Another basis for the division may be related to respective views on etiology. One would suspect the D-O group to lean toward a hereditary-constitutional etiologic hypothesis, while the A-P group would be more "environmentalist." Unfortunately, this specific hypothesis was not tested, and it can only be stated that such a correlation need not, and may not, exist. Thus, the theoretical and therapeutic aspects may both vary between the groups. Within the A-P category there are also variations, depending upon the degree of psychological insight and working-through attempted and desired. Various differences between the groups will be discussed as the data are analyzed in terms of the over-all results between the three groups.

RESULTS

Selected material from the survey will be presented. Space limitations preclude discussion of the entire results as well as the presentation of tables and statistical data which have been prepared. References to tables and statistical data will be done when it is believed necessary for clarity or to demonstrate significance. Significance of differences has been taken for a "p" value at the five per cent level.

Information regarding their professional training indicated 37 of the 60 members replying had had three years of residency training (61.7 per cent). Ten members (16.7 per cent) had had four years or more of residency. Seven members had obtained two years of training (11.7 per cent), and three members had one year (5 per cent). Only three members reported no residency training at all; presumably these physicians had been in the practice of psychiatry before residency programs were established and were admitted to the American Psychiatric Association from experience or training that satisfied requirements. Of the ten members having four years or more of residency training, three were in the A-P group (16.6 per cent of the 18 A-P's), two in the D-O group (8.3 per cent of the 24 D-O's), and five were in the S-R group (27.7 per cent).

Fifteen psychiatrists of the group (25 per cent) had been psychoanalyzed. More specific data was not obtained, such as the type of analysis, duration, etc. Of these 15, only two had completed institute training with their personal analysis. This correlates well with current data from the American Psychoanalytic Association which lists only two active members in the entire state of Minnesota.⁷

A question regarding the amount of training in the subspecialty of child psy-

⁷ American Psychoanalytic Association, *Roster of the American Psychoanalytic Association, Inc., 1959-1960* (New York: American Psychoanalytic Association, 1959).

chiatry was also asked. A great deal of the psychiatric practice for children in this area is carried on by the psychiatrists trained to work with adults. Only nine of the sixty psychiatrists were found to have had one year or more of training in child psychiatry. The largest group was that of 21 members (35 per cent) who had received no psychiatric training whatsoever with children. Eighteen (30 per cent) had three months training in child psychiatry; eleven (18.3 per cent) had six months training; and one (1.7 per cent) had had nine months. There are only seven certified child psychiatrists in the state of Minnesota.

It would seem apparent that the great majority of children with behavioral disorders in this locality are being seen by nonpsychiatrists. This includes not only social workers or psychologists working in child guidance centers and clinics, but those unaffiliated with any medical setting, such as in schools, child development centers, and churches. As in most illnesses, the family physician or pediatrician must also be handling a great many cases with widely varying capability. He may or may not make a referral depending on his own diagnostic acumen, along with the feasibility of referral and financial status of the family, among other considerations.

The psychiatrists were asked for the most common diagnosis among their patients—neuroses, psychoses, character disorders, psychophysiologic reactions, or acute and chronic brain disorders. The largest group checked was that of "neurosis." Forty psychiatrists checked this diagnosis (66.7 per cent) and one other checked neurosis and psychosis as equally divided. Eight members listed "psychosis" as the most common diagnosis and eight listed "character disorder." Three others specified the most

common diagnosis for outpatients as neurosis, and for inpatients as psychosis. The eight seeing mainly psychotics were divided between six D-O's and two A-P's.

It was also requested that they evaluate patients in terms of whether they were private (paying patients), charity cases, veterans, or college students. Forty-eight members saw predominantly private patients (80 per cent), while eight saw mainly charity cases (13.3 per cent), and three mainly veterans. One was listed as seeing primarily college students.

Only about one-quarter of the Twin City psychiatrists do physical and/or neurological examinations on their patients all the time. Thus 14 respondees (23.3 per cent) stated they always did a physical examination while 16 (26.7 per cent) specified they always did a neurological examination. One member mentioned he always did a physical and neurological check on hospitalized patients, but never on outpatients. The largest category was that of "occasionally" (less than 50 per cent of the time) doing physical and neurological examinations with 22 (36.7 per cent) answers stating this regarding physicals and 19 (31.6 per cent) regarding neurologicals.

This breakdown is highly significant. The chances of such a distribution occurring randomly between the three categories is less than 5 in 1,000. Thus, it is believed this points up one of the basic differences between the groups as the entire A-P group either never did examinations (55.6 per cent) or only did so less than half the time (44.4 per cent). Conversely, half of the D-O group did physicals, and two-thirds neurological examinations, all the time. The S-R's fell between these two extremes.

A broad question of significant import—in view of much past and pending debate

regarding the most feasible and desirable manner of paying for medical care—was inserted by asking Twin City psychiatrists their opinion regarding methods of payment for psychiatric care. Four possibilities were presented:

- (1) The status quo system is adequate.
- (2) Private insurance companies should expand their coverage (financially, and as to types of treatment and duration thereof) for mental illness.
- (3) The government should provide bigger grants to public clinics to care for those not able to pay for private psychiatric care.
- (4) A comprehensive government health insurance plan should be instituted that provides full coverage for mental illness along with any other illness when treatment is deemed necessary by a physician.

The biggest response was for an expanded coverage by private insurance companies with 30 checking this reply (50.0 per cent). However, the second most frequent choice was for a comprehensive government insurance plan, with 15 favoring this (25.0 per cent). Only eight members (13.3 per cent) supported the status quo, and six (10.0 per cent) believed the solution was for bigger government grants to public clinics. This would appear to be of interest, as approximately one-fourth of Twin City psychiatrists would appear to be in favor of the hotly debated "government medicine." One-half are putting their hopes in private insurance companies. There are some interesting results when a breakdown by therapeutic orientation and political preferences is made.

A further check was made to see if there was any significance to the preference for payment of medical care as correlated with political preferences.

Results showed that of the eight members favoring maintenance of the status quo, only one was in the A-P group, and he was a Democrat. The distribution by

psychiatric groups had five in the D-O group and the remaining two in the S-R's. However, by political preference there was quite an even distribution, with three Democrats, two Republicans and three without affiliation.

The 30 members who favored expanding the private insurance facilities had 9 in the A-P group, 15 in the D-O group and 6 in the S-R group. By political preference there were 5 Democrats, 16 Republicans, and 9 without affiliation. One member expressed no interest in politics. The largest contribution favoring expanded private insurance would thus appear to be the Directive-Organic psychiatrists with Republican political orientation.

As might be anticipated, the 15 members in favor of a comprehensive government health insurance program for psychiatric care were overwhelmingly Democrat. Thus, 13 of 15 (86.6 per cent) indicated this political preference, with two having no preference. Only one of the 15 was in the D-O group, with seven A-P's and seven S-R's. The "p" value of less than .005 for political preference and payment preference is also highly significant, indicating this distribution is not random. The deduction may be made that this pattern is another fundamental qualitative difference between the groups.

The next section inquired about gross income. There were six categories varying between less than \$10,000 to more than \$30,000 annual income.

The data indicate that 95 per cent of Twin City psychiatrists have a gross income over \$15,000. The largest single group, of 30 per cent, averaged more than \$30,000, and, when viewed by therapeutic orientation, this broke down into a composition of two-thirds D-O members and one-third S-R members, with no A-P member making more than \$30,000 gross an-

nual income. Also, while 79 per cent of the D-O's make over \$25,000 per year, only about 17 per cent of the A-P's do.

The next part of the survey dealt with the psychosocial histories of the psychiatrists. It attempted to secure information on marital status, religion, socioeconomic class, political affiliation and community participation. The marital status question showed 54 respondees (90 per cent) were married and had only been married once. These figures would appear interesting in view of nationwide figures now indicating a divorce rate of one in four marriages.⁸ Attempts at explaining this can only be speculative and would have to consider the stigma of a psychiatrist getting divorced in a midwestern community, the effects training and/or personal therapy may have had on his marriage, superior economic status, etc.

Inquiry was made as to the place of birth of the psychiatrist's mother and father. This was an attempt to determine what percentage of the psychiatrists were first-generation Americans. For 19 psychiatrists, both parents had been born outside the United States (31.7 per cent). In eight families, only one parent had been born outside the United States, making a total of 27 psychiatrists with one or both parents born outside this country. It would thus appear that almost half of the Twin City psychiatrists are first-generation Americans. Of these 27, thirteen list themselves as Protestant, seven as Jewish, five as Roman Catholic, and two with no religion. By therapeutic orientation, thirteen were in the D-O group, eleven in the A-P group and three in the S-R group.

The predominant religious denomination to which the sixty psychiatrists belonged was Protestant with 37 (61.7 per cent) checking this answer. Four of those so checking, however, specified that they

were Unitarians. The next largest group was that of Roman Catholic, with ten so responding (16.6 per cent). Seven answers were checked as Jewish (11.6 per cent) and six (10 per cent) with no religion.

There was a heavy concentration of Protestant members in the D-O and S-R orientations with a relatively balanced distribution in the A-P group among the different religions. This distribution by therapeutic orientation and religious preference is significant at a .007 level; i.e., the probability is less than 7 chances in 1,000 that this particular distribution would occur.

When these figures are compared with those of the maternal and paternal religions, a shift in the psychiatrist's religion from that of his family upbringing is noted. There has been an increase in the number of Protestants and Unitarians, at the expense of the Roman Catholic and Jewish religions. Thus, only 10 psychiatrists listed themselves as Catholic, although 18 mothers and 13 fathers of the psychiatrists were listed with this religion. Similarly, there were nine Jewish mothers and eight Jewish fathers, but only seven psychiatrists listed Judaism as their current religion.

When asked if they were currently active in their church affiliation, only 36 (60 per cent) replied that they were. All ten Roman Catholics listed themselves as currently active, while four of the seven Jewish psychiatrists stated they were. Of the Protestants, only 22 of the 37 felt that they were active in their churches, and three of these were Unitarian. However, when it was asked whether they intended to give religious training to their children, 47 (78.3 per cent) answered yes and only 15 (21.7 per cent) no.

⁸ "Family Breakdown Called Number 1 Social Problem in U. S.," *New York Times*, November 12, 1961, p. 48.

The data on numbers of siblings and sibling rank are quite fascinating. Of the 60 psychiatrists who answered the questionnaire, 21 (35 per cent) were the youngest members in their families of origin. Fourteen were the oldest members of the family (23.3 per cent) while nine (15 per cent) were only children. Thus, only 16 psychiatrists were not the youngest, oldest or only child.

The breakdown by therapeutic orientation is significant.

It may be deduced that some factors other than chance are operating when 10 of the psychiatrists who are youngest children have an A-P psychiatric orientation, and also with respect to the ten oldest children, who have a D-O orientation. The preponderant number of A-P psychiatrists who are youngest children is striking. They are over half of all those who are in this category in the Twin Cities; i.e., 10 of the 18 A-P psychiatrists (55.5 per cent).

Conversely, the paucity of youngest children who have a Directive-Organic orientation is equally striking; they compose only four of the 24 (16.7 per cent). The largest

° Class I (upper)—Families with considerable wealth. The head of the family is highly educated and is a major professional person or an important executive.

Class II (upper middle)—The heads of families are college graduates. They are lesser professionals or second-line business executives.

Class III (middle)—The family head is a high school graduate with perhaps some further training in college or a business or a trade school. He may be a shopkeeper, a salesman, a white-collar employee, or a skilled factory worker.

Class IV (lower middle)—The family head is most typically not a high school graduate. He is usually employed as a semi-skilled factory worker.

Class V (lower)—The family head is not educated beyond the elementary level and works as an unskilled factory hand or laborer.

number of older children were in the D-O group, with 10 of 24 present (41.6 per cent). Difficulties arise in offering hypotheses to explain this finding; the problem is why different groups of psychiatrists may be predisposed to different psychiatric approaches as correlated with their sibling position. A hypothesis I will propose is that the youngest member of a family more often seeks teleological explanations, as contrasted with the oldest sibling who may be conditioned towards taking direct action in situations, and perhaps later has less interest in metapsychological and theoretical aspects of psychiatry.

Data on social class was approached from three viewpoints: the social class the physician felt himself to be in at the time, the class in which he was raised, and the class status of his wife's family background, if married. The classification was based on that of Hollingshead's five classes.⁹

By this classification all of the psychiatrists should be in either Class I or II at the present time by virtue of their education, income, or area of residence. It is of interest that only 18.3 per cent of those answering felt they were in Class I; i.e., where they would be considered a "highly educated" person.

These results would agree with the findings of Hollingshead and Redlich in their sample, as only 37 per cent of their Class I respondents identified themselves with the "upper" class and 56 per cent classified themselves as "upper-middle" class. The "tendency toward the mean" would appear to apply to the psychiatrist's self-image.

The general distribution of the wife's family background was similar to that of the physician's, with the exception of twice as many coming from Class I backgrounds

as their husbands. When these data are broken down more specifically, by comparing the social class the physician comes from with that of his wife, the trend toward upward social mobility is apparent, although the largest number married women from their own social class. There were 18 psychiatrists who married into a social class higher than that in which they were raised and two-thirds of this group were D-O oriented. However, this was only significant at a "p" value of .08.

The 11 psychiatrists who currently list themselves in Class I and the 49 in Class II were also divided by the social class their wives had been raised in.

This result is at variance with the New Haven study, where the A-P group was much more aggressive in their aims and accomplishments toward upward social mobility than the D-O group. This difference may be explained by the different historical backgrounds of the two areas. In the Twin Cities the D-O group of psychiatrists are not predominantly from "old-line American stock." Neither do they come from predominantly later than first generation American stock. Of the 27 first-generation psychiatrists in the Twin Cities, 13 have been noted to be in the D-O group. The situation can best be explained in terms of most psychiatrists in this area being "in the same boat," in terms of past backgrounds and current ambitions, apart from their different therapeutic approaches.

Another factor that must be considered is the training facilities for the A-P psychiatrists in the area. Until the post-World War II period, the only psychoanalyst in the area was a child analyst at a child guidance clinic, and there are still no facilities for obtaining psychoanalytic training. The great majority of men taking their psychiatric training in Minnesota

end it there and do not go into more advanced graduate psychiatric training such as psychoanalysis or research. Such factors may explain the basic social similarities among Twin City psychiatrists of divergent psychiatric views.

There were 10 mixed marriages among the 60 psychiatrists reporting. Mixed marriage was simply defined as a marriage where the partners have different religions. In four cases the husband was Protestant and his wife Catholic; in one case the husband was Catholic and his wife Protestant. The other five cases showed the psychiatrist to have no religion while the wife was Protestant in three cases and Catholic and Jewish in each of the remaining two cases.

The division by therapeutic orientation in these mixed marriages showed four A-P and six D-O members. Again, these data contrast with Maciver and Redlich's New Haven data which showed 60 per cent of the A-P group and 40 per cent of the D-O group having mixed marriages.¹⁰ The Twin City figures reveal only 16.7 per cent mixed marriages composed of 22.2 per cent of the A-P group and 25 per cent of the D-O group.

Political affiliation turned up some surprising revelations; there were four more Democrat responses than Republican. An almost equal three-way split between the two parties and those without any political affiliation was present. The other thing to note is that two out of three psychiatrists are identified with one political orientation.

The preponderant numbers of analytic-psychological psychiatrists are further noted to be Democrats; conversely, the majority of Democratic psychiatrists are A-P identified in their orientation. When the D-O group is examined, their major contribution is to the Republican party, and most of the Re-

¹⁰ Maciver and Redlich, *op. cit.*, p. 164.

publican psychiatrists have a D-O orientation. This political data does agree with the New Haven study where 60 per cent of the A-P group were Democrat, and none were Republican; 50 per cent of the D-O's had no affiliation.¹¹

In the Twin Cities, 61.1 per cent of the A-P group were Democrat, while 11.1 per cent were Republican. For the D-O group, 50 per cent were Republican and 16.6 per cent Democrat. The remainder were unaffiliated. As indicated from the statistical figures, this distribution is quite significant, giving a further differential characteristic between the groups.

In conclusion, it should be stated that 56 of the 60 psychiatrists participating in the study were happy with their choice of specialization and would so specialize again if given the choice.

SUMMARY

At this point it may be beneficial to obtain a composite picture of the three groups of psychiatrists practicing in the metropolitan Twin City area. Such generalizing tends to obscure individual variations, which may be quite wide within each group, but it does provide some orienting landmarks. This will serve to give perspective regarding the composition and practice of psychiatry in a given community.

The first fact is that only approximately 30 per cent of the local psychiatrists are psychoanalytically oriented in their practice. No one in the area practices psychoanalysis predominantly, and most of the 30 per cent are not actually carrying out intensive, reconstructive therapy, which is also noted from other parts of the questionnaire pertaining to how frequently patients are seen and how long they are in treat-

ment. The most typical Twin City psychiatrist thus utilizes an organic or short-term directive psychotherapeutic approach, and this predominant orientation is found in all sectors of the psychiatric field.

The most common diagnostic group of patients seen by the psychiatrists were neurotics, and 80 per cent of those answering saw predominantly private, paying patients. Some revealing information was obtained with respect to how frequently physical and neurological examinations were performed. Over-all figures indicate they are always performed only 25 per cent of the time, and the majority of the A-P members never do them.

While half of the Twin City psychiatrists favored expanded coverage by private insurance companies to help pay for psychiatric care, the second highest number (one-fourth) favored a program of comprehensive government health insurance. The overwhelming majority in favor of government insurance were Democrats, and when the payment preferences were checked against political affiliation, the distribution was also found to be highly significant. There was almost a three-way split politically between Democrats, Republicans, and those without an affiliation. Thirty per cent of the psychiatrists answering the form had a gross income over \$30,000, which made up the largest single income group.

Fifty-four of the psychiatrists were married once and had remained so. Approximately 60 per cent of the members were Protestant, which indicated a slight drift into this religious affiliation, with an accompanying decline in the number of those in Catholic or Jewish faiths. A significant and fascinating finding was in respect to sibling position; over half of the A-P group were the youngest children in their own families, while about 42 per cent of the D-O group were oldest children.

¹¹ *Ibid.*, p. 695.

A question which the author has been interested in relates to why a course of organizational development proceeds in a given direction at a certain time and place. This paper has attempted to establish data upon which relevant hypotheses could be constructed. The geographical, historical, cultural, and medical influences have all had their share in shaping the Twin City psychiatrist. The public and the remainder of the medical profession have also contributed to the molding of the psychiatrist by their demands for a specific type of serv-

ice, either as patients or colleagues who will be referring patients.

Thus, the conclusion may be offered that the majority of people in the Twin City area desire their psychiatrists to be basically D-O or S-R oriented, and this is what they currently have. A change in the predominant orientation or in the type of services demanded is highly unlikely. This is not entering into the argument as to whether a change would be an improvement or a regression. It has been thought of in both ways by different groups.

JOSEPH W. EATON, PH.D

Adolescence in a communal society

Adolescence is a problem age in the American culture. Some educators assert that anxieties are a "natural" and therefore unavoidable by-product of physical growth and maturation. Anthropologists have reason to throw cold water on this notion. Adolescence is not universally a period of strain and stress. The degree of anxiety, as well as the areas in which it occurs, are culturally conditioned.¹ This theory is strongly supported by evidence on what

happens to Hutterites during their adolescence.

The Hutterites, whose origin as a sect goes back to 1528, are a closely knit group of Swiss-German origin who had lived together in neighboring villages in Europe for a long time before they migrated to the U. S. from southern Russia between 1874 and 1877. The immigrants—101 married couples and their children—settled in eastern South Dakota. Their descendants had, by 1964, spread over a wide area in the Dakotas, Montana and the prairie provinces of Canada. They live in over 110 hamlets, which they call colonies. They are a remarkably cohesive group; each grown-up is intimately acquainted with hundreds of other members in the settlements. The Hutterites believe it sinful to marry outside the sect, and nearly all of the present members (over 14,000) stem from the original 101 couples.

Cardinal principles of the Hutterites are

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The data were obtained over a period of 25 years, including two field studies directed by the writer; one on co-operative farming under the sponsorship of the Rural Settlement Institute; the other on "Cultural and Psychiatric Factors in the Mental Health of the Hutterites," supported by grants from the National Institute of Mental Health.

¹ See, for example: Mead, Margaret, "Coming of Age in Samoa," in *From the South Seas* (New York: William Morrow & Co., 1939).

pacifism, adult baptism, the communal ownership of all property, and simple living. Jewelry, art and over-stuffed chairs are regarded as sinful luxuries. Radio sets and the movies are taboo. Children are the only possessions to which there is no limit; the average completed family in 1950 had more than 10.

The Hutterites cling to their own customs and are considered "different" by their neighbors, but they are not primitive in the ethnographic sense. They get a grammar school education and speak English fluently. They read daily newspapers, have telephones and, in most colonies, own trucks. Since their own members are not encouraged to seek formal education beyond the primary grades, there are no doctors or lawyers among them, but they utilize such professional services from outside. Each colony engages in a highly mechanized form of agriculture. Their business with the "outside world," as Hutterites are apt to refer to their neighbors, usually exceeds \$100,000 per year per colony.

MATURATION WITHOUT CRISIS

The fifteenth birthday marks a turning point in the life of a young Hutterite. His colony starts to treat him like an adult. For a few years the older folks will continue to speak of him as a "young boy" or "girl" until he or she gets married. But in terms of social roles, the attainment of the age of 15 signalizes the end of childhood.² The following concrete changes take place on this birthday:

1. The adolescent leaves school.
2. A boy is voted a regular job by the baptized male assembly. He is assigned as a trainee to assist one of the department heads and to do general farm work. A girl joins one of the crews of women who do the cooking, baking, cleaning, gardening and other female chores on a rotation basis.
3. The youngsters begin to eat in the adult dining

room. On the day before the fifteenth birthday, one would find them at the head of either the boys' or girls' table in the children's dining room. Now they take their place at the end of their respective table with the adults on the bench, moving up as they grow older.

4. A girl is given a hope chest for her clothes and personal possessions. She also receives a rolling pin to make noodles, a task not assigned to younger girls. Boys get work clothes and heavy boots.
5. Youngsters begin to receive the monthly cash allowance of adults to buy personal "extras," (about one dollar).

EDUCATION

A Michigan State College study³ showed that future school and job plans of many of the tenth- and twelfth-grade Michigan pupils interviewed were beyond their means of achieving them. Barring major change, many of them will be disappointed. More twelfth-grade boys hoped to be professionals than can be, while only one-third of the proportion of twelfth-grade boys expected to enter clerical and sales work as compared to the percentage of high school graduates who have entered these occupations in the past.

No such widespread disparity between expectations and reality is likely among

² For more details on the contemporary culture of the Hutterites, see: Eaton, Joseph W., in collaboration with Robert J. Weil, *Culture and Mental Disorders* (Glencoe, Ill.: The Free Press, 1955); Eaton, Joseph W. and Albert J. Mayer, *Man's Capacity to Reproduce* (Glencoe, Ill.: The Free Press, 1954); Kaplan, Bert and Thomas F. A. Plaut, *Personality in the Communal Society* (Lawrence, Kan.: University of Kansas Press, 1956); Eaton, Joseph W., "Folk Obstetrics and Pediatrics: A Case Study of Social Anthropology and Medicine," in Jaco, E. Gantly, ed., *Social Prospectus on Behavior* (Glencoe, Ill.: The Free Press, 1958).

³ See Social Research Service, *Youth and the World of Work* (East Lansing, Mich.: Michigan State College, September, 1949), pp. 3-5. This study was based on a representative sample of sixth, seventh, eighth, ninth, tenth and twelfth-grade high school students in all parts of Michigan.

Hutterite youngsters. Our survey was not based on similar systematic inquiry, but few of the Hutterite adolescent boys and girls interviewed by our staff expressed strong dissatisfaction with their educational achievements.

Hutterites are insistent that education should not go beyond the eighth grade or include much more than reading, writing, and arithmetic. "Too much learning gives people funny ideas about themselves" is the common view of Hutterite elders. They consciously raise their children to be *colony people*. No alternative careers are held out. Young people are indoctrinated to meet the occupational requirements of their religious way of life.

Boys grow up with the knowledge that they may be called upon to do any of the chores around the farm, from driving a tractor, to manure-spreading, carpentry or slaughtering. If they show particular aptitude for one of the specialties, such as shoemaking, carpentry or machine repairing, this may result in their assignment as apprentice to the adult in charge of the specialty. Many prefer to work with tractors and trucks, jobs that require fairly frequent trips into town. But it is uncommon for competition for these work opportunities to become intense. The differences in available jobs is never so large as to lend itself to prolonged and embittering struggle.

Young girls are taught early to accept the idea that, until after their marriage, they cannot hold a position of responsibility. They will work under the tutelage of older women in cooking, washing, dressing meat, gardening, nursing and homemaking. Individuals' preferences are expressed for one type of work rather than another. The community will recognize this whenever there is an opening in a work area.

Severe dissatisfaction with occupational achievement among the Hutterites is rare.

This may be related to the absence of differentials in financial compensation. Skilled repairing of tractors brings no greater rewards than sheepherding. All Hutterite youngsters will eat the same food, dress the same way and have fairly equal opportunities of meeting members of the opposite sex, regardless of their work.

Manager, teacher and preacher wield power and influence while they hold their position. But these positions of prestige are accessible to all males as they acquire seniority and demonstrate a special aptitude. With the exception of advantages which accrue to sons and daughters of leaders who can more diligently teach leadership skills and occupational specialties to their offspring, all Hutterites have similar opportunities for achieving a position to which they aspire. Differences in rank are primarily based on achieved social status.

There are people who express dissatisfaction with their work. But we found few instances where they were the focus of strong and long-term conflicts. In small intimate groups, such as those constituting every Hutterite village, sources of irritation quickly become common knowledge. The preacher or boss is likely to take remedial steps to give the frustrated individual adequate satisfaction before irritations mature into the kind of bitterness that similar conflicts of career ambitions are likely to assume in the larger American scene.

THE PREVALENCE OF SOCIAL DEVIATION

There is an increase in communal toleration of deviant behavior after children leave school. Hutterites give some recognition of the needs of adolescents to think for themselves. There is a relaxation of discipline at the very time when youngsters feel that as "grown-ups" they should

be allowed to try things that are forbidden. Old folks remember fondly that "we were pretty bad when we were that age but we grew out of it."

Corporal punishment is now rarely administered to adolescents except for severe sins, such as fornication and theft. Even then, a youngster must ask for the punishment before it will be administered after a formal resolution of the elders. The more or less spontaneous striking of adolescents by their parents, quite common in the last generation, has rarely been reported by our informants.

Many colony people avoid noticing when youngsters slip out of the house at night to hitch a ride to town to attend a movie. Disobedience to parents and elders—a certain invitation to a severe "licking" when done by a 10- or 12-year-old—is shrugged off philosophically or at most is retorted to by the admonition, "You should be ashamed to talk like that to your mother." If unauthorized behavior occurs too often and too openly, punishments are administered. The most common forms are a "bawling out" by the Hutterite religious teacher in Sunday School, in front of all other unbaptized youngsters. "Standing up in church" is another method of discipline involving reference group shaming.

Boys are expected to get into at least

a "little trouble" during adolescence. Their work brings them into town quite often and makes them the subject of temptations of the outside world. If they get into "bad trouble," such as making sexual advances, stealing or doing something that would court arrest or a fine by the authorities, there will be severe disapproval, mixed with an invitation to return to the fold as a repentant sinner. Temporary rather than permanent status loss is likely if the deviant reforms.

Girls are rarely punished. Hutterites think their "nature" is better. They have fewer opportunities to "misbehave," for they get to town less often than boys. Their work keeps them in the colony and isolates them from outside temptations. They certainly are not often caught in acts that outrage their community.⁴

The following chart shows behavior regarded as sinful, with rough estimates of their frequency, based on a screening survey of the Hutterite population between 1949-1952:

⁴ The urge to "kick over the traces" exists in them, of course. It is quite apparent in their projective test responses. Yet there are strong internal and cultural restraints on their acting out of impulses. For details, see Kaplan, Bert, and Thomas F. A. Plaut, *Personality in the Communal Society* (Lawrence, Kan.: University of Kansas Press, 1956).

VIOLATIONS OF HUTTERITE MORES *

<i>Offenses against the state and Hutterite mores</i>	<i>Male</i>	<i>Female</i>
Murder, embezzlement, assault and other felonies	None	None
Petty theft from non-Hutterites	5	None
Sale of homemade wine	2	None

* A screening survey of the entire Hutterite population was made between 1949 and 1952, covering the entire life space of those then living, about 8,600 persons. The qualitative ratings of frequency were based on anthropological evidence from many informants, both Hutterite and non-Hutterite, including police and school officials. Numbers are cited when the deviation is of the type to become a matter of record. Some of them occurred several decades ago. The incidence of major deviations in any one year is quite small.

For details about the survey methodology, see Eaton, Joseph W. in collaboration with Robert J. Weil, *Cultural and Mental Disorders* (Glencoe, Ill.: The Free Press, 1955).

<i>Offenses against community mores</i>	<i>Male</i>	<i>Female</i>
Stealing colony property	Rare	Very rare
Getting kickbacks from colony business from dealers	Rare	None
Cheating on expense accounts	Occasional	Very rare
Selling colony property for private gain	Very rare	Very rare
Working for private gain for neighbors	Occasional	None
Trapping animals to sell fur	Occasional	None
Owning a gun	1	None
Owning a musical instrument	Rare	Very rare
Letting photographs be taken	Common	Common
Wearing worldly clothes	Occasional	Rare
Going to movies	Occasional	Rare
Visiting neighbors without permission	Occasional	Rare
Writing letters without mailing them through preacher	Common	Common
Being careless with community property and causing damage	Occasional	Occasional
Shirking work	Occasional	Occasional
<i>Offenses involving interpersonal relations</i>		
Disobedience to parents or elders	Occasional	Rare
Lying	Occasional	Occasional
Malicious gossip	Common	Common
<i>Offenses involving personal behavior</i>		
Smoking	Occasional	Rare
Heavy drinking	Occasional	None
Reading "bad" literature such as <i>True Story</i> magazine	Common	Common
Failure to attend church	Occasional	Occasional
<i>Offenses involving sex</i>		
Masturbation	Common	?
Homosexuality	None	None
Sodomy	None	None
Premarital sex relations	Rare	Rare
Prostitution	Very rare	?
Necking	Common	Common
Petting	?	?
Rape	1	None
Telling dirty stories	Common	Occasional
<i>Offenses involving abandonment of Hutterite colony</i>		
Permanent deserters	106	8
Temporary deserters who returned	141	3
Men who volunteered in the armed services of the U. S. or Canada	26	None

The Hutterite culture prescribes a narrow path for its people. They have little trouble with secular criminal laws. Yet there is more difficulty in adhering to Hutterite taboos that are positively sanctioned in the American culture. As shown in the foregoing tabulation, Hutterite leaders report most trouble in getting compliance from their adolescents to their taboos on the acquisition of private property, wearing worldly clothes, playing of musical instruments, enjoyment of worldly recreation, gossip, pre-marital sex play in courtship and leaving the community. These "sins" against Hutterite mores are "all right" or positively evaluated by the general American culture.

One of the crucial decisions every Hutterite adolescent must make is: "Shall I stay with my people?" He is free to leave at any time. Parents and elders avoid being "too hard" on youngsters lest they leave the community for good. Those who "try the world" are always welcome back home. More than half of the "run-away" adolescents who have returned become members in good standing. The rareness of permanent desertions from the parental hearth no doubt also reflects the effectiveness of Hutterite childrearing practices. Youngsters are so well-indoctrinated that they grow up to need the kind of communal support which their culture offers them. Few can do without it. Even when leaving, most boys have one or more "partners." Only the rare person is independent enough to take such a step alone.

Hutterites go to the outside without much preparation in dealing with its expectations. Most of them talk with a slight accent, have little knowledge of how to dress, do not know worldly manners and generally can make a living only by doing menial chores. They are not likely to meet middle- or upper-class individuals. They

must associate largely with that section of the population who frequent cheap hotels and furnish seasonal labor. The prejudices of many worldly "outsiders" against anyone who is different do not generally help to make for a pleasant stay away from home. In South Dakota and Alberta, discriminating "Nuremburg" legislation restricts the rights of Hutterite communities in purchasing land.

The world "outside," despite its bright lights, gets to look pretty grey when measured against the warmth of their own community, the three square meals it assures to all, the powerful farm machinery available to do the work, and the secure social status accorded in each colony to all members of good standing. After youngsters stay away long enough and have faced the realities of existence in a highly competitive and impersonal society, most of them are ready to go home.

The struggle which goes on inside the breast of many a young Hutterite between the adventures awaiting them in the secular world and the narrow confines of love, security and familiarity in their community is reflected in the following accounts of adolescent "deserters:"

Peter M., age 17.

"I'm going away. You see if I don't do it. I've already got a partner and we have a job with a farmer. I am going to make some money and come back."

John H., age 21.

"When I was 'out' I met the nicest girl in Bigtown. I really loved her. Yes, she loved me. And they had the nicest home. They invited me over. Her father was a credit manager, but they knew I was a Hutterite and did not care if I was. Oh, I would not marry her because I wasn't sure I wouldn't go back to the colony. Oh, she would not want to live there; she has so many things outside.

"I wrote my mother several times that I was grown up and that she must let go of me. But you can't stand against it long. She might really

have become sick and died over [worrying about] me. Once I came back and stayed for a couple of days. I did not even change into colony clothes but kept the ones I had bought outside. My mother begged me to stay. I promised to return for good in three weeks, but it was three months."

In many a boy, the "girl I left behind" is an important motive for his return. Children who have been reared carefully to put a high premium on feminine virtue, genuine affection and patriarchal domination in marriage are not likely to find girls outside who can meet these requirements. Also, "outside" girls are not willing to marry "down" in the worldly social ladder, to become the wife of an ex-Hutterite who would be disowned by his own family and community for such a step.

MORATORIUM ON SIN

There is a partial amnesty on "sin" during adolescence. The community works with each youngster with patient consistency to indoctrinate him effectively to live up to what is considered right. The hope is that after going through a period of being "wild," he will settle down and become a good member. The reins are never taken off, but they are held less tightly during the late adolescent period.

Baptism plays an important role in this adjustment process. Hutterites, like all Anabaptist Christians, believe that only adults should be baptized. Only they are mature enough to knowingly assume the responsibilities and limitations of their faith.

Baptism affords the opportunity to remove all accumulated guilt. The ceremony is preceded by a period of spiritual preparation, during which people study religious literature and talk to their

teacher about the Hutterite way to live. There is a private interview with the preacher, who asks for a confession of all sins not previously confessed. This act of confession is believed to expiate the sins. When the baptismal water is sprinkled on the youth at the church service, he can start life with a "clean slate." The present generation of youngsters tends to delay the age of baptism longer than their elders. Some explain their decision quite openly by stating: "We want to have some fun before settling down."

Adolescents get an opportunity to peek a little behind the curtain of faith drawn by their culture. Most of them are indoctrinated sufficiently well so that they lose interest in what they see. For instance, one young man known well to the writer had installed a crystal radio set in his bedroom. He and other adolescents listened secretly to radio programs at night. Several years later when he was revisited, he was asked: "Where is your radio now?" The boy, now a married man with one child, replied, "That was kid foolishness. I am sick of all that cowboy music now. I know now that it isn't any good. We all have to go through this period before we settle down." The rebel of yesterday is well on his way to becoming an elder of tomorrow.

Adolescent adjustment is also facilitated by the fact that in several areas which tend to become problematical for American youngsters, the Hutterite culture "greases" the path for its young people so that they will glide along it smoothly. This problem of continuity-discontinuity in cultural conditioning has been stated with refreshing clarity by Ruth Benedict: ⁵

"All cultures must deal in one way or another with the cycle of growth from infancy to adulthood. Nature has posed the situation dramatically. On one hand, the new-born baby, physio-

⁵ Benedict, Ruth, "Continuities and Discontinuities in Cultural Conditioning," in Mullahy, Patrick, ed., *A Study of Interpersonal Relations* (New York: Hermitage Press, 1949), p. 297.

logically vulnerable, unable to fend for itself or to participate of its own initiative in the life of the group; and on the other hand, the adult man or woman. Every man who rounds out his human potentialities must have been a son first and a father later, and the two roles are physiologically in great contrast; he must first have been dependent upon others for his very existence and later he must provide such security for others. This discontinuity in the life cycle is a fact of nature and inescapable."

CONCLUSION

The Hutterite culture softens the discontinuity of child and adult roles with regard to the selection of a career, work requirements, the assumption of responsibility for one's behavior and the disciplining of one's impulses. It encourages children to participate meaningfully in the life of the adult community. There is a gradual ascent into the adult world, beginning with the kindergarten. The Hutterites have this in common with many cultures, including that of many American rural farm people. The generalization made by Benedict, based on her references to the Papago Indian culture, also applies to the Hutterites:

"The essential point of such childtraining is that the child from infancy is continuously conditioned to responsible participation while, at the same time, the tasks that are expected of it are adapted to its capacity. The contrast with our [American] society is very great."⁶

The adolescent period reflects the struggle of Hutterites to maintain their own way of life in the face of competition with the general American culture. The sect has been influenced strongly by American ways. Yet, at the end of the process, we find considerable adherence to Hutterite expectations, of his own free will, by the youngster of yesterday. Adolescence is the period of test where parents learn whether or not they have succeeded in bringing

their children up to live their way. Most Hutterites do, if judged by the fact that youngsters remain at home to carry on where their parents will leave off.

The Hutterites may not be well-prepared for life and participation in the big world. But there is no question about their effective socialization process. Religion, tradition and the active manipulation of parents and leaders work hand-in-glove to bring up Hutterite young people to want what their way of life can give them. This is done at the price of placing a negative value on social mobility. In the face of considerable competition with American values for the souls of their children, Hutterites have a well-thought-out system of social control. The sect has its deviants, but most violations of the common core of values are not a threat to the group's survival.

One can speculate that many Hutterites would become severely disorganized if the protective support of their community were suddenly removed by urbanization as was the case with the Molokans;⁷ but this is unlikely in the near future. The Hutterites carefully restrict their arena of contact. They migrate as a group to new land if additional acreage is needed to support their population. Their social cohesion remains strong.

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⁶ *Ibid.*, p. 300.

⁷ Young, Pauline V., *The Pilgrims of Russian Town* (Chicago: University of Chicago Press, 1932).

Freud's contributions to psychiatry

The new Freud Building at the East Moline State Hospital in Illinois may be the first and only hospital building in the world named in honor of Sigmund Freud. Dr. Gerhart Piers, director of the Institute for Psychoanalysis in Chicago, said in a letter to Martin S. Sloane, M.D., former superintendent of the hospital:¹

Dr. Seitz is one of a team of consultants from the Chicago Institute for Psychoanalysis who travel 175 miles from Chicago each week to bring a co-ordinated program of clinical service, training and research to the patients and staff of the East Moline, Ill., State Hospital. This program is supported, in part, by a research grant (No. 17-100) from the Illinois Research and Training Authority.

This paper was adapted from an address presented at the East Moline State Hospital on October 5, 1961, at dedication ceremonies for a building named in honor of Sigmund Freud.

¹ Konstantin D. Dimitri, M.D., is the present superintendent of the East Moline State Hospital.

"Yours may be the only hospital building in the world dedicated to the memory of this pioneer who discovered a new world in his own office. There are memorial plaques in various places: one on the house where Freud was born in Freiberg, Czechoslovakia (which the Communists may well have removed by now), one on the 'Haus in der Berggasse,' of which the Viennese themselves are hardly aware . . . and there is even a settlement house for workers in Vienna named the 'Sigmund Freud-Hof'. . . . As far as I know, however, there are no other hospital buildings named for Freud."

Naming one of the buildings at East Moline State Hospital in honor of Sigmund Freud seems in keeping with the progressive policies and programs of this hospital, its superintendent and its staff. This hospital, for example, was the first mental hospital in Illinois to develop an

extensive open-door policy for its patients.

In addition, this is the first state hospital anywhere to have a staff training program in the form of a co-ordinated team of consultants from a psychiatric center in a fairly distant city. This is a hospital which, in my experience, is without parallel in the extent of its contact with and co-operation from the community it serves. I would say, therefore, that it is fitting that this hospital, of all state mental hospitals, should be the first to honor the name of Freud in this way. It deserves and has earned the honor that Freud's work, memory and name confer upon it.

In this presentation I shall try to review some of the high points of Freud's discoveries, his contributions to psychiatry and something of his personality and genius. I may as well admit at the outset that I am unable to be completely detached or objective about Freud; I still retain a respectful awe at the power and scope of his great mind. On the other hand, neither am I very objective about Aristotle, Pythagoras, Copernicus, Isaac Newton, Charles Darwin, Albert Einstein, Paul Ehrlich or Jonas Salk.

I have not outgrown a youthful hero worship of those giants of scientific research. Freud himself, however, with his characteristic sense of humor, insisted that he was not a genius and set out to prove it by reasoning that: "Geniuses are unbearable people. You have only to ask my family to learn how easy I am to live with, so I certainly cannot be a genius."

Freud's scientific discoveries fall into three main categories. First, and perhaps foremost, he discovered a new method for studying the mind, the method of psychoanalysis. Second, he developed a comprehensive body of theory about the workings of the human mind, a theory unequaled in its depth and scope and explanatory

power. Finally, Freud contributed a method of treatment for some forms of mental illness. This method, in its original and pure form, is finding increasing application and, in various modified forms, has a place in the treatment of a large proportion of mental diseases.

Freud said about his own discoveries that it seemed to be his fate to be the discoverer of the obvious. He said that artists and writers had already known about everything he discovered. If Freud's discoveries dealt with the obvious, however, it was not because his gifts as a scientist were so limited, but because he worked in a field—the field of personality, behavior and mental disease—in which the phenomena of everyday life were the data that he studied.

How did he study these phenomena? What method did he develop for studying the mind in all its depths and complexities? Let us go back to the beginnings of psychoanalysis and see how the method of psychoanalysis began.

Psychoanalysis started with a patient who could be considered the true inventor of this method for studying the mind: a woman whom Freud called Anna O. in his writings. Her contribution was that she wanted to talk about her mental suffering and wanted someone to listen. She was a social worker. Despite the various attempts to prove that all of the early psychonalytic patients were seriously disturbed and schizophrenic, there is no evidence that this was true of her.

Her real name was Bertha Pappenheim. The psychologic suffering that she wanted to talk about was mainly hysterical in nature; e.g., dissociated states and unreal dream experiences. What was unusual about her was that she wanted to talk about this and found a willing ear in a Viennese internist, Dr. Joseph Breuer. She

was very literate, spoke English, and so did Breuer. They conducted the treatment in English, which may have been important (diluting some of the intensity and impact of the experience for both the patient and doctor). She invented the term "chimney-sweeping" for the procedure of talking out her disturbing thoughts and feelings to Breuer.

Her treatment went on for over a year and came to naught. We know now that Anna O. developed a transference neurosis, so that it became more important to her to see Breuer than to get relief from her symptoms. Mrs. Breuer knew that, too, became jealous of Breuer's prolonged treatment of Anna O. and insisted upon the family's taking a long sojourn in Italy. Anna O.'s treatment had been recorded by Breuer, however, and a number of years later came to the attention of Sigmund Freud, who used it as the basis for developing psychoanalysis.

A cornerstone of psychoanalytic theory ever since Anna O.'s procedure of "chimney-sweeping" has been the concept of something in the mind that could be "swept out," some "dark, dirty" material which, if removed, would improve matters, unclog them, free them. That concept in psychoanalysis follows the surgical model for treatment of abscess; i.e., drain the abscess and gain relief of symptoms.

The concept of "chimney-sweeping" became the concept of "mental catharsis." At first it was thought that the "abscess" in the mind consisted only of "ideas" or thoughts; but soon it became clear to Freud that the ideas must be charged with emotion. The main issue in the treatment, therefore, was to get at the emotional charge and drain it. Since the patient sometimes did not want to be "drained," the technique was the same as for surgery—force the patient. Since almost everyone was using hypnosis

at that time, Freud tried hypnosis to force the patient to "drain his psychic abscess."

Freud's early writings about using hypnosis revealed that, as in the case of Anna O. and Dr. Breuer, the patient tended to come back for more and more hypnotic treatments but resisted "draining the psychic abscess." Freud then developed the theory that there must be some force between the underlying "psychic abscess" and consciousness that kept the "abscess" from becoming conscious.

This new concept led to a change in technique; viz., the patient was allowed to struggle with his resistances. Hypnosis was no longer used; instead, the patient was encouraged simply to let his thoughts wander freely and to talk about whatever came to his mind. The technique of free association, which is the foundation of the psychoanalytic method, had been discovered.

The method of psychoanalysis has become one of the most important techniques available to us for studying the internal workings of the mind. Freud devoted his life and his career to a study of the mind by that method. He stated:

"My life has been aimed at one goal only—to infer or to guess how the mental apparatus is constructed and what forces interplay and counteract there."

No one before Freud had used or even tried the method of simply encouraging another human being to talk about himself to a trained, impartial listener for an hour a day, four or five days a week, for weeks, months and even years on end. One of the reasons that many people are unable to understand some of the strange-sounding findings and theories of psychoanalysis is because their human experiences do not include anything of that kind, either as the talker or the listener. When one does have such an experience, either as the one

who does most of the talking or the one who mainly listens, he finds quickly enough that the mind is a much deeper, more subtle and complex thing than he had imagined or supposed. One finds that mental events, even those that seem the most fleeting and insignificant, have their causes, mechanisms and effects. "In the [workings] of the [mind]," Freud said, "There is nothing trifling, nothing arbitrary, [nothing] lawless."

When I turn to Freud's theoretic contributions, I realize that these are so numerous and far-reaching that I cannot possibly do justice to them in such a brief discussion as this. Instead, I shall focus upon just one of his principal discoveries, a fundamental and pivotal one—that of the Unconscious Mind.

Soon after he developed and began to use the method of psychoanalysis, Freud found that many of his patients' thoughts, feelings, attitudes and behavior could not be explained satisfactorily on the basis of what the patients consciously knew about themselves. Freud concluded that some of the most important wishes, strivings and other forces in the mind must be "not conscious" or unconscious.

One of Freud's greatest strokes of genius was that, whereas most people of his time thought either of neurologic activity in the brain on the one hand, or of conscious mental functioning on the other, Freud could conceive of a psychologic life consisting of wishes, fantasies and dreams which exist in the same sense that the external world exists, even though the person might not be consciously aware of its existence. We assume that the external world exists whether we are looking at it or not. Freud could conceive that the same is true of our inner psychologic life.

That discovery of Freud's is so simple that it is difficult; i.e., the concept that the

essence of mental functioning is not conscious. The discovery of an Unconscious Mind relegated man's consciousness to the role of an inner sensory organ; i.e., consciousness is like an "eye" of the mind which, when focused upon particular elements in the constant stream of unconscious mental activity, can make us conscious of the specific elements upon which the "eye" of consciousness is "gazing."

The concept of an Unconscious Mind was opposed strenuously by many people when Freud originally proposed it, and to this day it remains a subject of controversy for some. One of the reasons that mankind may object to and resist this concept is because it lowers our self-esteem. To realize that consciousness of mental processes is not all-important makes us feel less the master of our own minds than we thought we were. Just as Copernicus wounded man's self-esteem by his discovery that the earth is not the center of the universe, and, similarly, as Darwin injured man's self-esteem still further by finding that we do not have a separate or unique creation, so was it another blow to mankind's self-esteem when Freud discovered that our consciousness is only a small and relatively insignificant aspect of mental functioning.

Utilizing his new theoretic concept of an Unconscious Mind, Freud found that many phenomena of everyday life, as well as many phenomena associated with mental disease, could be explained better by postulating the role of unconscious forces in the mind. Even such everyday activities as telling jokes, forgetting things that one tried to remember, common superstitions and certain religious beliefs could be traced to sources and origins in the unconscious workings of the mind.

Dreams became an important source of data about the Unconscious Mind, so

much so that Freud called dreams "the royal road to the Unconscious." Freud once said about the many disagreements with his theories: "People may abuse my doctrines by day, but I am sure they dream of them at night."

What sorts of things go on in the Unconscious Mind? What does that part of the mind contain and what are its characteristics? The Unconscious Mind is made up of many things and compared with consciousness is a relatively much larger part of the mind—like the seven-eighths of an iceberg that is submerged. Freud found that this portion of the mind at its deepest levels contains the instinctual drive forces of the organism; e.g., sexual drives, aggressive-competitive drives, maternal drives. In addition, Freud found that the Unconscious Mind is a reservoir of primitive emotions and passions such as those of love, hate, shame, guilt and fear.

The Unconscious Mind also contains an elaborate, hidden fantasy life which goes on constantly without our slightest awareness of it. Finally, Freud found that the Unconscious Mind is the great storehouse of memories. Like a giant electronic computer that has been programmed with millions of data fed into its reels of recording tapes and wires, the Unconscious Mind records and stores the millions upon millions of experiences that we have had since the day we were born. The basic unit of mental structure is the memory trace, and it was Freud who discovered that most of our memory traces—in fact, the great bulk of our memory structure—is not conscious.

In his studies of the unconscious memory life, Freud made another of his important discoveries; viz., that the period of infancy and childhood is more important in psychologic development than had been realized previously. Formerly, many people

had thought that what happens to a baby or infant could not be of much consequence since, they believed, the small child did not register or record its experiences.

Freud found that, if anything, the opposite is the case. Precisely because the infant is in such a relatively embryonic, inexperienced, and, one might say, "open-minded" state, he is more susceptible to the effects of his experiences, more impressionable than the adult. Because his mind is so incompletely developed, having a relative lack of memory traces with which to cushion or buffer his new experiences, the small child is also more vulnerable to painful, traumatic, overly intense experiences. That is why we protect children from exposure to experiences and activities that would overexcite them.

Freud's studies of childhood memories led to his important concept of "psychic trauma." That concept refers to experiences which are overly intense; i.e., experiences that activate an excessive amount of excitation within the mind. The memories of overly intense or "traumatic" experiences are relegated to a portion of the Unconscious Mind that is sealed-off from the rest of the personality. Walled-off, encapsulated memories of that kind, resulting from traumatic experiences during infancy and childhood, are among the most potent sources of later symptom formation and mental disease.

Freud developed an important theory of anxiety in human beings based upon these concepts. He postulated that the infant, flooded with excessive stimulation that cannot be stopped or eliminated—e.g., a baby having a crying fit—must experience acute discomfort and "mental pain." He reasoned that infantile states of over-stimulation may be the prototypes or precursors of what later comes to be called and felt as fear. What we call anxiety may be

fear of the repetition of such a traumatic state; i.e., fear that we might be overwhelmed or flooded again with painfully intense stimulation that could not be stopped, mastered or controlled.

Everyone has a storehouse of such painful infantile experiences and all of us carry the dread of helpless exposure to unbearable stimulation into our adult lives. The human infant, having the longest period of helpless dependence upon parents of any animal, probably suffers more such traumatic states than has been realized in the past.

Freud found also that the kinds of pleasures and satisfactions we craved as infants tend, to a variable extent, to be retained in our Unconscious Minds as adults. Many human activities—e.g., many ways that people pursue that elusive will-o'-the-wisp called "happiness," are based upon attempts to satisfy unconscious infantile cravings carried over from early childhood. Freud said in this connection: "Happiness is the deferred fulfillment of [an infantile] wish. That is why wealth brings so little happiness; money is not an infantile wish."

In his explorations of the Unconscious Mind, Freud acknowledged that there was one aspect of human psychology which he had never been able to clarify or understand satisfactorily; viz., the psychology of women. With his usual humor, Freud said: "The great question . . . which I have not been able to answer, despite my 30 years of research into the feminine soul, is 'What does a woman want?'" Evidently it will take a greater genius than Freud's to solve that age-old question.

Now to turn to psychoanalysis as a form of treatment for mental disease. Freud himself was least satisfied with this aspect of psychoanalysis. Because the method of psychoanalysis requires so much co-opera-

tion from and participation by the patient in his own treatment, psychoanalytic therapy is most useful in those forms of mental disease which do not involve too extensive or generalized damage to the personality but are confined to certain parts of the mind, leaving other parts of the personality intact.

That fact is responsible for the paradox that psychoanalysis, the most prolonged, extensive and also expensive form of treatment that we have for mental diseases, tends to be used in less serious, less progressive forms of mental illness. Modifications of psychoanalytic therapy are used with considerable value, however, in the treatment of a large proportion of mental diseases.

To some extent, although not completely, psychoanalysis as a form of treatment has been oversold. Psychoanalysis is by no means the "last word" in the treatment of the mentally ill. It is part of the infant and child in us that makes us look for panaceas and magical cures of all kinds. Freud himself consistently understated the results of psychoanalytic treatment. He said, for example: "[The goal of psychoanalysis is] to substitute for neurotic misery, ordinary human unhappiness." To those persons who demanded of psychoanalysis that it produce a more upstanding and moral human being, Freud answered: "Why should analyzed people be altogether better than others? Analysis makes for [more] unity [of the personality] but not necessarily for goodness. . . . I think that too heavy a burden is made on analysis when one asks of it that it should be able to realize every precious ideal."

On the other hand, neither should we underrate psychoanalysis as a form of treatment. It is the treatment of choice in an increasingly wider range of psychiatric conditions, and when it is applicable,

psychoanalysis offers the best chance of a definitive, etiologic cure.

Some people have complained that Freud was too pessimistic about human psychology and that the picture he painted of mankind—viz., full of primitive passions and destructive urges—made the future prospects for the human race dim indeed. It may be that Freud tended to be somewhat pessimistic, although one might argue that he was only too realistic. He did recognize, study, and even emphasized, however, the strength, force and importance of the rational side of man's nature.

He said in this connection: "The voice of the intellect is . . . soft . . . but . . . does not rest until it has gained a hearing . . . this is one of the few points on which one may be optimistic about the future of mankind." The fact that the rational side of man "does not rest until it has gained a hearing" constitutes a constructive and persistent force in human nature; we may look to this force for mankind's future progress.

So far in this discussion I have concentrated on Freud's scientific contributions, primarily in the field of psychiatry. His contributions go far beyond that field, of course, having had important influences also upon general medicine, the arts, religion, ethics and education. I shall not try to review Freud's contribution to all of those fields but instead will offer some personal glimpses of Freud as a man.

Freud was very much a family man, beloved by his devoted wife and five children. One of his children, Anna Freud of England, has carried on his work. His other children have gone into a variety of fields. Freud had a number of hobbies in which he maintained a lifelong interest; one was archeology. He often compared the work of the psychoanalyst with that of the archeologist; both were at-

tempting to reconstruct more complete pictures of the past from bits, fragments and relics of data which have survived to the present. Freud was Jewish, although not religious, and referred to his Jewish background frequently, often humorously, in his writings. Someone has said that the world today is struggling with the ideas of four great Jews: Christ, Marx, Einstein and Freud.

Freud was an accomplished writer. At one time he was awarded Germany's Goethe Prize—perhaps comparable with the Pulitzer Prize in the United States—for the literary merit of one of his works. He said about himself: "I have to be somewhat miserable in order to write well." Some of the titles of Freud's writings have a literary ring that illustrate his talent as a writer; e.g., *Totem and Taboo*, *Moses and Monotheism*, *The Future of an Illusion*, *Beyond the Pleasure Principle*, *Civilization and its Discontents*.

Freud's writing style was simple, straightforward and clear. One of his students, Hanns Sachs, said about Freud's style of writing and lecturing: "While I was listening eagerly to Freud's lectures, I studied assiduously his technique of exposition . . . I wondered how he succeeded in producing something unexpected and stupendous while his talk moved in simple terms, dispensing with the fireworks of baffling profundity or of glittering paradoxes. I found that he made use of Schopenhauer's recipe for a good style: 'Say extraordinary things by using ordinary words.'"

From what I know of Freud, he would not have wanted to be just eulogized, and certainly not idealized, in a dedication speech of this kind. Freud knew his own limitations as a human being better than most of us do. No matter what might be said about his human foibles

and limitations, however, the greatness and lasting importance of his contributions to psychiatry cannot be doubted.

Among the great men who have contributed significantly to this field, Freud's place is assured by "his unusual combination of intellectual zeal and common sense, his balanced and often rueful sense of the total image presented by the human person, . . . never expanding upon one or two favorite notions out of keeping with the rest" (A. Kazin). If psychoanalysis has been oversold, Freud was not its salesman;

he can be held responsible only for having discovered and developed this important new method of approach to, and body of knowledge about, human behavior.

If Freud were still alive, I think he would have been pleased by the honor of having a building at East Moline State Hospital named in memory of him. The personal glory would have meant little to him; but I think he would have been gratified to see the extension of his work into state mental hospitals and the recognition of its potential value there.

Reception in a psychiatric outpatient clinic

Untrained in the techniques of psychotherapy and armed only with a knowledge of office skills, the receptionist will many times be challenged to cope with the vagaries of the patients attending a psychiatric outpatient clinic.

While it is true that contact is on a superficial level, the interchange may be more than a perfunctory greeting or channeling of the phone call. Often when patients are on a long-term therapy basis, a genuine relationship with the receptionist is established. Thus, the contact with the receptionist should be regarded in the total context of the patient's therapeutic experiences in the clinic. How the receptionist relates to the patient should be of utmost concern to the professional staff.

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Most patients who attend clinics are fully capable of accepting the clinic routine. The more severely disturbed, however, may present different problems to the receptionist: a depressed person dissolving in tears on entering the office; a hyperactive youngster making a quick dash for the typewriter, banging on it with cyclonic fury; or a newcomer, apprehensive about his first contact with the psychiatrist, persistently asking questions. And most painful to the receptionist could be the query: "Do they think I'm crazy?"

The writer still recalls—with some degree of balefulness—her first experience with a seriously disturbed adolescent who had difficulty in expressing himself. On approaching the desk, he did nothing but stare. It seemed as though he wanted to say something but would not respond to any question. Wondering if he was deaf or mute, and wavering between annoyance

and puzzlement, I continued to try for quite awhile to get him to talk. A psychotherapist finally helped out.

Quite obviously, then, reception in a psychiatric clinic is not a routine function wherein one has only to be courteous, smile pleasantly and know rules and regulations. Reception in this setting is different from others because of the difference in the caller—a disturbed person. To “receive” in a psychiatric clinic requires more than a pleasant “good morning” and a charming demeanor.

The receptionist learns to “play it by ear.” Since she has not been prepared academically, she must rely on her intuition in order to deal with the unusual situation. She learns quickly that her function is not merely monitoring patients to their seats. Rather, how she reacts will depend on her own sensitivity, her humanitarianism and whatever good judgment she has.

The question then arises: Is this sufficient? Let us consider some of the problems that can and have developed.

With some patients, a kindly and sympathetic gesture on the part of the receptionist is interpreted as an “open sesame” to have a therapy session in the office, thus seducing her into usurping the role of the therapist. Excessive enthusiasm and empathy can also result in a problem of overidentification with the patient.

Conversely, the receptionist may be forced into an attitude of brusqueness with overly demanding individuals, or she may be overwhelmed. The writer recalls seeing one receptionist, a warm and kindly person, practically immobilized by an elderly woman who kept bewailing her unhappy fate for about 20 minutes. The patient's voice boomed out as she condemned all nurses and doctors. What forbearance this young woman employed as

she tried to explain to this patient that she was making an appointment for her to see the psychiatrist!

A word can become a catalyst for an explosive outburst. Witness the poor receptionist who inadvertently told a patient he was to see a psychiatrist. His previous contacts had been with a case-worker and he had probably forgotten or had been confused in his understanding about seeing “a doctor.” On hearing the term, psychiatrist, he appeared shocked and became abusive and vituperative.

The receptionist also services the clinic by answering the telephone. This can be a routine function but if the call is from a prospective patient, who is fearful, timid, and oftentimes embarrassed, she has to be warm, encouraging and even persuasive in eliciting necessary information (when a professional worker is not immediately available). Even more problematical for the receptionist are the “hyperventilators.” These talkers pour out their troubles in one lengthy sentence. Cutting through this cascade requires the utmost tact and discipline. Rare is the receptionist who has not wrung out her ear and mopped her brow after being overwhelmed by an avalanche of language. “All I said,” she will moan, “is ‘who’s calling, please.’”

How to elicit an answer to a routine question may require the greatest diplomacy. For example, a caller made an inquiry about clinic hours. The receptionist politely replied: “You are interested in coming to the clinic?” “Who’s interested?” the caller yelled: “They tell me I need it. Who wants to come? They say I got to. So I’m calling.”

How can the receptionist be assisted to function most effectively?

One must first acknowledge these questions: What kind of orientation does the

receptionist receive when she starts to work? Is there a consistent relationship between the professional staff and the receptionist to help, guide and advise her in her contacts with the patient? Or is she left, after her initial introduction, to employ trial-and-error methods which may sometimes be at the expense not only of her own feelings but also of the patient's needs?

As part of her initial training there should be a thorough discussion on the aims of the clinic, the patients served and the nature of the services offered. Lines of communication between receptionist and professional staff should always be open so that problems can be aired and a better understanding developed. Briefings on new patients should be held on a

regular basis so that the receptionist can be alerted to any problem a particular patient may present. Although it is impossible to anticipate unusual reactions, the receptionist can be helped to learn "what to do until the professional worker arrives."

Since she is a nonprofessional worker, the receptionist has feelings of isolation from the staff which can best be avoided if she is accepted as a member of the team. Reception should be fully recognized as an integral part of the operations of the clinic. As the first person to greet the patient, and often the last to bid him farewell, the receptionist can be helpful in establishing a climate of warmth and acceptance. Thus, she can function as a bridge to the therapist.

STEVEN POLGAR, PH.D.

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The group interview in mental health research: Methodological aspects of an inquiry among prehospitalization associates of schizophrenics

I. INTRODUCTION

Those concerned with problems of mental hygiene are beginning to collect data from sources broader than the clinical situation. Interviewing family members, peer groups, or coworkers outside of a hospital or agency setting can contribute to our knowledge of the interrelationship between social processes and individual psychological crises.

This paper is concerned with methodological aspects of gathering information from groups of friends and coworkers of patients who knew them prior to hospitalization.

In 1955, the Division of Neuropsychiatry of Walter Reed Army Institute of Research, in collaboration with the Department of Psychiatry of Walter Reed Army Hospital, initiated an investigation, directed by Lieutenant Colonel Kenneth L. Artiss, on therapeutic methods applicable in, and phenomena relevant to, the course of schizophrenia (1).

Among the phenomena included in the project were the events which precipitated the onset of symptoms leading to referral. We, the writers—an anthropologist and a psychiatrist—investigated the antecedents of hospitalization for patients who had completed from one to twelve years of service in the army before being diagnosed as schizophrenic.

Interviewing about such events in a group situation is related to a number of procedures common in anthropology and psychiatry as well as other fields, but it also differs from them to some extent. Group interviewing has been used by anthropolo-

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gists, most commonly in situations where circumstances prevented them from interviewing informants singly.

Paul reports that among the Navahos "the group situation often renders others present eager to tell their own stories, but it unquestionably results in statements of 'public' attitudes and diminution in the freedom of communication of some feelings" (7).

Chandler interviewed workers in the garment industry with a view to comparing their responses in individual and group interviews. She found a close correspondence between the two types of materials, although there was some distortion and crystallization of individual feelings to get them in line with those of the group (3).

Some advantages of the group interview are cited by Nadel:

"In the case of interviews which bear on secret and forbidden topics, I have found it most profitable to stimulate the emotionality of a few chief informants to the extent of arousing almost violent doubts and controversies. The expression of doubt and disbelief on the part of the interviewer, or the arrangement of interviews with several informants, some of whom, owing to their social position, were certain to produce inaccurate information, easily induced the key informant to disregard his usual reluctance and to speak openly, if only to confound his opponents and critics" (6).

In psychiatric settings, interviewing is used in a number of contexts. Foremost among these is the psychiatric interview, "a situation of primarily *vocal* communication, in a *two group* . . ." (9), *italics in the original*). Even in group therapy, where this dyadic relationship is abandoned, the purpose of gathering information is subordinated to therapeutic goals. Situations where information is the primary goal occur when, for example, families of patients are interviewed in order to assess pre- or post-hospital adjustment in epidemiological re-

search. The family, however, has a very different perspective from the peer group of a patient, and techniques applicable with the former are not necessarily the best with the latter.

II. THE GROUP INTERVIEW

A. Preliminaries

We interviewed 30 groups of about 13 patients. In each case we selected the individuals making up the group by asking the first sergeant who knew the patient best. Some names had already been given to us by the patients, who had been interviewed prior to our departure.

The people suggested by the first sergeant and by the patients were asked in turn for their suggestions. This sometimes led to a difficult situation. After having heard the reason for the interview some informants became acutely anxious again about their own possible contribution to the patient's "breakdown," and tried to tell their story immediately or denied having any important contribution to make, rather than just giving out names. The investigators had to discriminate between ignorant and guilty informants and often raised the level of anxiety of the overready informant by asking him to hold off until the group met together.

The physical surroundings during the interview are important for setting the tone and for the quality of the tape recording. Chandler's interviews were held in the informal atmosphere of lunch-pail groups in the factory, the plant cafeteria or a public restaurant. Our interviews were usually held in the company day room and we asked to have coffee provided. The prerequisites of good acoustics for recording often gave us the advantage of a fairly isolated location also.

B. Interviewers

Bushard, Erikson and Marlowe (lieutenant colonel and privates, respectively, and who interviewed the associates of schizophrenics in the first phase of the Walter Reed study which dealt with patients who had been in the army for less than two months) made good use of the military status gap between them to clue in their recruit informants on the range of permissible behavior (2).

We could follow their example in this regard since one of us (J. A.) was a captain and the other (S. P.), a private.

Our informants were induced to talk by their involvement in the stressful events leading to the hospitalization of the patient. A friendly officer from the medical corps and an enlisted man, who came a long way to hear their story, were a suitable audience even though they had no long-term relationship with them. We feel that most informants expressed themselves with relative freedom under these conditions.

In the self-presentation we made to the informants, we changed somewhat from formality to informality, especially with respect to loosening neckties, and other items of military protocol. During the first few interviews we were not too aware of the effects of our self-presentation; but both of us, more aware of the informants' reaction to the other interviewer, soon discovered the importance of such clues. We also came to use army colloquialisms, to the extent of our ability, and attempted to pick up any expressions common in the post or unit we were interviewing.

C. The Initial Period

Our informants assembled at the place and time of the interview on the instruction of their military superiors. First, we mentioned to them that the results of our in-

quiry were important for medical research purposes, and also stressed confidentiality. Some written schedules were administered at this point, lasting about 30 to 40 minutes. They included a modified Fiedler Assumed Similarity scale (4) and a Likert-type scale designed to measure status-dependent attitudes toward the patients. The results of these instruments were mainly inconclusive and need not concern us further here.

Some informants protested that they couldn't fill out the questionnaires; e.g., "Sir, I didn't know the man well enough." In not a few cases it was apparent that this was a further sign of tension about participating in the interview. The hostility of such informants was little-disguised under their prominent use of formal means of address. We tried to show acceptance by sympathizing: "Yes, I know these questions are difficult," and followed up with a limit-setting: "But do the best you can." It is likely that the tests increased tension and the desire to tell one's story.

After the schedules were collected, we asked the informants to draw their chairs into a circle and called their attention to the tape recorder by asking them to give their names each time before speaking and not to deposit their coffee cups on the table which had the microphone on it.

With the tape recorder in operation and the identifying information dictated, the psychiatrist started things going by the question, "Well, what kind of a guy was John Doe?" Occasionally there was too much tension for such a question and we first went around the circle asking each informant to state how long he had known the patient, information that he had just written down on a questionnaire. But even in these instances we followed up with the nondirective question, since we wanted to "shape" responses away from short answers to direct questions so that the informants

and not we would determine the path of the interview.

It was often clear that the group misapprehended our purpose; e.g., "Why would the Army send two people all the way from Washington?" they wondered; the true reason was usually not sinister enough to fit with the average soldier's conception of "Washington." In most cases, however, this suspicion was dispelled by the end of the interview, if not sooner.

D. The Main Body of the Interview

The first reaction of the basic trainees studied by Bushard, Marlowe and Erikson was to recount all kinds of singular things the patient had done. One informant occasionally became a "protagonist," trying to defend all the actions of the patient. All groups had a tendency to rationalize the behavior of the patient, and would not be comfortable in verbalizing the idea that the man was "insane." The response of our groups was similar. The initial response to our question "What kind of guy was John Doe?" can be seen in the following interview.

- A.: "He's hard to describe. I don't think you would notice anything about him. To describe him would be like describing anybody else in this room. [The patient] kept to himself so much. Except that he was very quiet. I remember many times that I would try to get to know him better, you know, spoke to him, start a conversation. The conversation would go on and then (*snaps fingers*) boom, that would be it. You know. He was very quiet."
- B.: "I agree with Lou on what he said . . . I didn't come into contact with him when we were working or anything else, but I got—it was very hard—he'd come in and get dressed and leave, wouldn't stay around, just didn't seem like one of the group around there . . ."
- C.: "One thing, I was barracks sergeant; what I first noticed about him really was that he was always lying in the sack upstairs. But once

you told him to do something he gave no back talk . . ."

Psychiatrist: (*turning to a silent informant*) "What kind of contact did you have with him?"

D.: "I didn't know the man, Sir, until I talked to his section sergeant, and he was releasing him from his section and he could work for me until such time as they transferred him to another section. I liked the boy. I really liked him. I spent a lot of time with him because—well—he seemed to have some problems . . ."

Usually we allowed considerable freedom of discussion during the first 30 minutes or so of the interview. We tried to go around the circle until every informant had spoken at least once.

As the interview progressed, we shifted to a more directive method of phrasing questions, including some about times, places and persons. The presence of two interviewers also allowed for better observation of nonverbal clues. While one interviewer paid more attention to building a "scaffold," a structure of inquiry, the other concentrated on watching and taking note of passing glances between informants, their leaning forward, or other indications of disagreement, boredom, or quickened interest (c.f. 5).

The interviewers alternated in assuming these roles. Interaction was encouraged by the interviewer who "carried the ball" at any particular time by his glancing at another informant or turning to him with a "what do you think of this?" Certain informants, especially if they were highly verbal and outranked the rest, occasionally tried to dominate the conversation.

In our first group interview we did not set limits to this and later found that the silence of one informant was resentment against such a domineering member of the

group rather than against us. The shift to more directive interviewing produced a shift in the mode of interaction. Informants interrupted each other more often as specific events were reported:

Anthropologist: "Did he see him about that jeep business when he left the jeep out at the party?"

E.: "Yes. I believe so, not that . . ."

F.: (*Interrupting*) "There was a big stink on that when he was up there."

E.: "I guess so, but . . ."

F.: (*Interrupting*) "That was the eighteenth."

E.: "I don't think he would talk too much about that, on account of everyone who was at the party; that would explain his actions at that particular time."

This period was also moderately high in tension release and joking. G. was talking about the patient's reluctance to enter conversations: "I was on temporary duty down here like (*patient*) and I can't help but get into these arguments (*laughter*). Like we would all sit around and talk about German girls . . . I talked about my wife—excepting Sgt. H.—he didn't say too much about his wife; she is too much larger than he is (*laughter*)."

One of the outstanding features of the group interview was the extent to which informants stimulated, supported and corrected one another. The most common phenomenon was the assumption by one of them of the role of questioner. One of the patients was a paratrooper and we were discussing why soldiers would volunteer for such an assignment.

I.: "... and I dare say not a man here ever thought about \$55.00 when he was standing in the door of one of those airplanes. How about you, J., did you?"

J.: "No, I never did."

I.: "K.?"

K.: "No, sergeant."

I.: "I took you across the motor two or three times with me."

K.: "I wasn't thinking about the money right then, sergeant."

I.: "How about you, L.? Did the money . . ."

L.: "No, not up in the plane, but I will tell you what, I keep my jumps down to a minimum of three months . . ."

I.: "I don't know, maybe they do jump for money."

M.: "If you weren't getting \$55.00 a month, would you want to stay here and jump?"

Support was asked and given by various means. Often an informant would ask another to confirm a statement: "... Also I noticed a sudden change in him. Do you remember the party we had here?" (*Turns to another informant who barely nods before the speaker goes on*). "He acted very well. But a few days after, one morning, he came in, he didn't even greet us, right?" (*again turns to same informant and continues*) . . ."

In another instance a man was reporting on his own interaction with the patient: "... Dave, correct me if I am misconstruing this slightly, but I think from the time that Dave and I first squashed this AWOL attempt, and I was really quite harsh about it . . ." "Hell, he put you in that position." This request for support was important when, as in this last case, the informant was guilty about his possible effect on the patient.

One more example may be cited:

N.: "I'd like to discuss this with Ken. Ken, remember when we were in the school, how sometimes he would walk over and say we weren't doing

this right, it should be done *this* way. Do you remember that?"

O.: "Uh huh."

N.: "My thoughts were that he was just a little bit jealous because we were put in charge of the school and he had more or less been left out in the cold. And that's what hurt me a lot because as far as I've been saying, we were very good buddies and I wanted Ken to bring out this point. I did think he was a little envious of us . . ."

It is tempting to speculate that this kind of information might have been heavily disguised or not revealed at all if the support of the group had not been available. In the last example N. even attributes the point he himself has just made to the second informant. In numerous other instances the informants disagreed among themselves about facts and interpretations of facts. This occurred among peers as well as among men of different ranks. In the following extract, for example, P. was a master sergeant and Q. a sergeant, a difference of two grades.

P.: "Gee, that's a surprise to me because as long as I'd known him I never seen him drunk. I always had the impression he didn't drink."

Q.: "He was drinking on duty when he was at troop command."

P.: "No, no, you are talking about Alan. See, I had never seen him drunk or anything like that . . ."

Q.: "He couldn't hold his drink, but he drank."

P.: "I knew him for four years and I never seen him drunk."

Q.: "He drank when he lived in . . ."

In the case of another patient, two sergeants first-class started disagreeing in the very first few minutes of the interview:

R.: "In my opinion he was quiet, easy-going, modest-like . . . He was fairly efficient . . ."

S.: "He worked for me. He was not an efficient lad in any way. He seemed to have some mental trouble, always worried; his mind seemed to wander; could never depend on him."

This difference was later resolved when it turned out that they had known him at different times. One man even went so far as to attribute the disagreement to projective mechanisms:

Psychiatrist: "Do you have anything on that?"

T.: "No, except that maybe we are describing, probably describing each one of our positions . . ."

The fact that the interview was recorded ceased to be of any importance after the first ten minutes. Not even deliberate reminders to give one's name before speaking spoiled this effect. Individuals who showed resistance before the interview and continued to feel uneasy not infrequently watched the spools on the tape recorder turning around and around, as if this would have a soothing effect on them. The fact is that we ourselves had been the ones who were anxious about the tape recorder, and it was one of us who shut the recorder off on his own initiative on one occasion when some "extraneous" information was being revealed, which was emotionally charged for him as well as the informants.

E. Termination

We found that the limiting factor in our interviews was our own time and our fatigue, rather than that of the informants'. After checking our notes to see if anything of importance had been omitted, we terminated the interviews by again going around

the room, asking each informant to give a final opinion:

Psychiatrist: "What do you guys think was his main problem?"

G.: "That is it; I can't see that he had a problem."

U.: "In fact, he seemed better adjusted than any of us here."

G.: "I mean, he was quiet, but it didn't seem like he had any trouble; me, I've got problems, money problems every month!"

V.: "Like the rest of us say, when all of a sudden you come out and find he is in Walter Reed Army Hospital, that he had a nervous breakdown, it seems impossible because when he was down here, he seemed he was an above average person."

U.: "That is what I wanted to ask. Are you going to tell us what it is? Is it a nervous breakdown, hallucinations?"

In other interviews the respondents continued to disagree to the very end:

W.: "I think if someone would have just taken time and put up with his idiosyncrasies for a while, he could have been a much better man and a much better soldier . . ."

X.: "I disagree with Ed because Lieutenant H. took up more time with (*patient*) than he took up with any three guys that come into this outfit . . ."

Y.: "He was a different personality the first day he got here. He wasn't even normal, or whatever you want to call it. He wasn't; he was different in some respects . . ."

After this final round, we asked the group "Now is there anything that you want to ask us?" In most cases they wanted to know what was "really wrong" with the patient;

often they asked if it would be permissible for them to write to him. In a few cases they went on to talk about themselves and their own unit, or about mental illness in general. This period we called the *catharsis*. It was during one of these that a young soldier turned to us and said "You know, I have been thinking about this and I have come to the conclusion that everybody is a little bit normal."

III. CONCLUSION

We have described a technique of group interviewing used with former associates of schizophrenic patients. This technique afforded us an opportunity to increase our awareness of a number of phenomena. Going over the recordings of the interviews convinced us that even the subtlest action of the interviewer would "shape" the response of the group. Self-presentation, anxiety about rapport or tape recording, directiveness of questioning, number of "uh hum" reinforcements (8), providing coffee, interviewer fatigue, and so forth, all seemed important.

Disagreement or competition between the two interviewers seemed to affect the quality of the interview in much the same way that covert disagreement between staff members in a mental hospital can affect the condition of a patient.

By compelling each informant to speak at least once at the beginning of the interview and by drawing out more upsetting information from the more talkative, eager individuals, we were successful in establishing group sanctions favoring the disclosure of highly sensitive material. It must be remembered that differences between interviewer and informants were not as great as they would be in a cross-cultural situation; that strong official sanctions brought all desired informants together at one time and place; that the medical label of the inter-

viewers denoted an atmosphere of confidentiality; and that the hospitalization of one of their comrades was a sufficiently disturbing event to provide the informants with a strong stimulus to speak about ordinarily sensitive matters.

We noted that, unsurprisingly, this kind of group interview has a therapeutic effect on the participants. The effect of publicly verbalizing feelings that had been previously suppressed is, of course, well-known in group therapy and psychodrama.

To conclude, on the basis of our experience, we recommend the group interviewing method to psychiatrists, social workers, educators, and social scientists interested in research on the variegated problems of psychopathology and mental health.

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The mental health program in a college health service

GENERAL AIMS AND GOALS OF STUDENT HEALTH

College graduates form a high percentage of the leaders in any community. "If educators and psychiatrists, together with workers in the related disciplines, can cooperate to produce a greater degree of emotional maturity in these college students, we may expect significant improvement in the approach to and solution of many of the social problems which the world faces."¹

In the words of Julian Huxley, "Man's control over nature applies as yet only to external nature: the formidable conquest of his own nature remains to be achieved."²

Today we face conflicts of ideologies and nations. Only mature, informed, and enlightened leadership, for which colleges strive to prepare their students, can preserve our civilization.

The American College Health Association,

at its 1961 meeting, heard Dr. Gordon Bergy discuss "The Need for Recommended Practices and Standards for College Health Services"³ and adopted the

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¹ Group for the Advancement of Psychiatry, "The Role of Psychiatrists in Colleges and Universities," *G.A.P. Reports*, 1(September, 1950). Report 17, p. 1.

² Huxley, Julian, *New Bottles for New Wine* (London: Chatto and Winders, 1957), 12.

³ Bergy, G., "The Need for Recommended Practices and Standards for College Health Services," *Student Medicine*, 11(December, 1961), 159-62.

recommended standards which have been published in *Student Medicine*.⁴ The objectives and scope of these recommendations are stated as follows:

"The ultimate objectives of any college or university health program are to maintain a state of optimum health, both physical and emotional, among the student body and staff, to indoctrinate each student with proper attitudes and to instill good habits of personal and community health. An adequate health program assures a healthful and safe physical and emotional environment, health education, and health care. It discovers physical and emotional problems in their early stages, when they may be correctable, prevents loss of time and promotes the pursuit of academic work by maintenance of health through the prevention and treatment of illness, and provides opportunity for research relating to basic health problems of the student and of his environment.

"The objectives of the health program and the methods for carrying out these objectives should be outlined in a health code which will serve as a guide for development of the program and as a protection to the college by defining its limits of responsibility for the health of the students and faculty.

"A good college health program is more than provision of first aid for accidents or of medical care for acute illness. It should be broad in scope, encompassing preventive medicine and psychiatry, health education, medical care, medical health care, and supervision of the environment. When it is properly organized and developed, it becomes an integral part of the educational experience of college students, demonstrating the importance and value of health as a personal and community asset. In order to be most effective, the members of a college health service should be active in all phases of campus life and be readily available for consultation. This requires a close reciprocal relationship with all departments concerned, but at the same time the confidential status between student patient and physician must be held inviolate."

The student who comes to college brings with him a complex emotional system which needs to be guided, cared for, and provided with the essentials for a healthy development to maturity. A satisfactory adjustment to college life is vitally important if the student is to obtain maximum benefits and satisfaction from his college experience. Colleges, therefore, have a responsibility to provide emotionally healthy environments for their students, as well as services to prevent or to care for unhealthy emotional reactions which are likely to occur in a percentage of college students.

THE COLLEGE AND MENTAL HEALTH PROBLEMS

"The college community is a place where students are not only studying but where they are also living. Everything in college is of consequence to their maturation. Thus, the policies of the college or university, its organization as an institution, and every aspect of its character are significant in the development of the student. Every American college has its distinctive way of operating, and this, to the observing and experiencing student, helps determine his conception of social order and what the grown-up world stands for."⁵

The faculty and administrative officers of a college, if they are properly qualified, should have an understanding of the general emotional needs of students and should provide basically healthy environmental resources: advisers, social, religious and athletic programs, and various forms of self-expression, including student government, journalism, dramatics, music, and numerous organized activities. Additional contributions to student mental health can be made by the college chaplains, by a psychological counseling and guidance program, and by the student health service.

While the administrative faculty is usually cognizant of social, academic, and

⁴ "Recommended Practices and Standards for College Health Services," *Student Medicine*, 11 (September, 1961), 34-35.

⁵ Group for the Advancement of Psychiatry, "Considerations on Personality Development in College Students," *G.A.P. Reports*, 2 (May, 1955), Report 32, p. 3.

extracurricular stresses and of the students' reactions to these, there are times when they may be unaware of the existence of emotionally stressful situations. Moreover, they may fail to associate the resultant behavior with the stress, or may consider it unimportant or transient. Sometimes a student's reaction to emotional stress evokes disciplinary responses from the administration.

Although discipline has to be maintained in college life,

"... the focus of all disciplinary action should not be the student breach of the rules and the imposition of punishment, but rather the discovery of the underlying problems of the student for whom constructive help should be provided. At the same time, the individual student's difficulties may reveal where and how the college can provide some helpful guidance or some alteration of the college community, which may reduce the liability of similar occurrences. In other words, a student "break," for whatever reason, could serve to illuminate some hazard of college life to the college, including the students, just as public health uses the incidence of various diseases as indication of potential danger to the community.⁶

In some colleges, as many as 59 per cent of enrolled students drop out before completing their courses. A considerable portion of these withdrawals are directly related to unresolved emotional problems. Aside from the adverse effect of such "drop-outs" on the individuals and on society, the "college loses, too, because often it has invested money, time and effort in the student, which is partially wasted when his emotional disorder results in his having to give up the continuance of his college education."⁷

THE EMOTIONAL PROBLEMS OF STUDENTS

When a young person is uprooted from his home environment and the immediate support of his family and is transplanted into

a college community, he has many adjustments to make. Moreover, while he is making these adjustments, much more is expected of him scholastically and socially than ever before.

Among the disturbances seen in college students are "adolescent adjustment reactions" (anxiety, depression, and so on) which are responses to the stress of adjusting in a new environment without the support previously available. "Normal problems of growing up" are encountered frequently; fortunately, these are usually transient and not incapacitating. "Acute reactions to stress" are more severe than the adjustment reactions and may be incapacitating for a period of time. They are usually neurotic in form, although they may appear as acting out behavior or, less often, as psychotic reactions.

Intensification of emotional disturbances already existing represents another problem. The stresses of adapting to life away from home and to the different environment and its demands may activate or intensify an underlying personality problem or psychotic process.

Any of the disturbances just mentioned may be manifested by a wide variety of symptoms. Most of these may be classified under two major headings: "acting out" behavior and "acting in" somatic reactions.

Acting out behavior occurs when the individual, as a result of some stimulus or stress, expresses unconscious impulses in various actions. The association between the stress and the behavior is rarely recognized by the person involved. This behavior is usually disruptive, although it may be constructive.

Examples of acting out are such forms of behavior as deliberately disregarding

⁶ *Ibid.*, p. 5.

⁷ See footnote 1.

college regulations (a display of unconscious resentment of authority) and cheating on exams (the result of a need to fulfill desires for accomplishment and achievement). Acting out behavior itself may be disruptive to the college environment. In addition, such behavior frequently evokes hostile and defensive counter-reactions on the part of others, thus impairing the efficiency of faculty, administration, and other students.

Somatic complaints of a psychogenic origin are usually forms of acting in. When unconscious impulses and feelings resulting from conflicting dependency needs, unexpressed hostility, and other sources of chronic anxiety are turned inward, they may find expression in such physical symptoms as headaches, dizzy spells, skin disorders, and digestive disturbances. When these reactions are severe, they usually cause much concern on the part of other students, dormitory personnel, and student health officials. Many of these conditions, however, can exist in chronic, milder forms which do not incapacitate the student, and come to light incidentally or through the investigation of apparently unrelated problems such as chronically low grades, overcutting, tardiness, and frequent minor illnesses.

THE STUDENT HEALTH PHYSICIAN AND EMOTIONAL PROBLEMS

The student health physician is seldom in a position to see all emotional disorders. Behavior problems in dormitories or classrooms may not be brought to his attention, and often he learns of them indirectly in conversations with other members of the college staff or with students. The personality disorders he sees are usually in students who have consulted him because of some other problem such as

inability to study and concentrate, or because of chronic symptoms which are often elusive and vague. Such students, as a rule, show a poor response to the usual methods of treatment, and their attitude may make them difficult to manage.

The emotional disorders most frequently seen by the student health physician in his regular practice are neurotic reactions and psychophysiological reactions. Psychotic reactions are encountered less frequently. By observing the frequency and etiology of these disorders, he can sometimes make recommendations to the administration and faculty regarding the prevention or correction of problems that may be contributing to emotional stress among the student body.

The student health physician can evaluate and treat most of the mild adolescent adjustment reactions and many of the acute reactions to stress, such as anxiety reactions, mild depression, and psychophysiological reactions. He may find it difficult to determine the extent and type of the emotional disturbance, especially in psychosomatic reactions and some borderline psychotic disorders. Time limitations and limitations related to his identity and position contribute to the problem of managing these patients in his usual practice. Some emotional disorders, especially those of long standing, cannot be successfully treated with the facilities usually available in a college setting, regardless of the competence of the personnel.

THE PSYCHIATRIST, THE PSYCHOLOGIST, AND STUDENT HEALTH

The psychiatrist, because of his medical training, has the ability to differentiate organic from functional conditions, and can assume medical responsibility when

necessary. He can assist the student health physician in the management of disturbed students, and can effectively treat severely disturbed students or make arrangements for their disposition. Consultation between the psychiatrist and the student health physician is facilitated by their mutual understanding of the anatomical, physiological, and pharmacological aspects of many cases involving emotional disturbances.

Unfortunately, many colleges do not have psychiatrists on the staff, or even available as consultants. It is an understatement to say that psychiatrists trained in student health or actively interested in the problems of college students are not plentiful.

Where psychiatrists are not available, the student health physician must assume responsibility for disturbed students, must be available for medical consultation with the psychologist, and must be prepared to refer more severely disturbed students to psychiatrists or hospitals near the student's home or to psychiatric resources in neighboring cities. Private psychiatrists, mental health clinics, and state psychiatric facilities are some of the resources which the student health physician may call on.

Some communities have social agencies staffed by trained social workers, to which students and their families can be referred for help with problems related to social and environmental factors. Other professional people who may be able to deal effectively with some of the adjustment problems and emotional stresses occurring among college students include ministers, social workers, and experienced counselors.

Qualified clinical psychologists, working closely with the student health physicians and with the administration, can be extremely helpful. The Committee on Clinical Psychology of the Group for the Ad-

vancement of Psychiatry has stated its belief:

"... that we [psychiatrists] should continue to follow the recent trend to refer some patients to clinical psychologists for special treatments, such as vocational guidance, remedial reading, retraining procedures, speech training, and psychotherapy. Naturally, the type of psychotherapy done by the clinical psychologist will depend upon his training and competence, the type of patient being treated, and the conditions under which the treatment is conducted."⁸

Increasingly, psychologists are being trained in the identification of emotional reactions, personality disturbances, and the etiological factors of the environment. Some psychologists have a penetrating insight into the special problems of adjustment to the educational environment. Many psychologists on college and university faculties are doing research studies on learning experiences, adjustment behavior, and other subjects related to mental health, in addition to performing clinical testing and assessment.

Some clinical psychologists have had training in the understanding of psychological factors commonly causing disturbances in college students. They may see students referred by student health physicians for psychological consultation, and provide counseling resources for some students with emotional or adjustment problems. In addition, they may serve effectively as consultants to the administration and student health physicians, assisting them with problems of student behavior, dormitory conditions, and decisions regarding the admission or discharge of students.

By co-operating with other individuals—

⁸ Group for the Advancement of Psychiatry, "The Relation of Clinical Psychology to Psychiatry," *G.A.P. Reports*, 1(July, 1949), Report 10, p. 3.

house officers or counselors, student government officials, chaplains, deans, and so forth—who help to provide services to students in their everyday life, the psychiatrist or psychologist can help them to become more effective in preventing the development or occurrence of severe disorders, and also in locating and helping emotionally disturbed students when early manifestations become apparent. The psychiatrist and his staff can also assist with the sometimes difficult problem of referring such students to appropriate treatment resources.

PSYCHIATRIC EVALUATION AND TREATMENT OF COLLEGE STUDENTS

When a student at Duke University is referred to the psychiatrist or seeks help because of his own concern, the first step is an evaluation of his condition. This process may involve one or more interviews with several professional people (including psychiatric social workers, clinical psychologists, and psychiatrists), or the evaluation may be done by the psychiatrist or psychologist.

The student is encouraged, in an accepting atmosphere, to describe his symptoms or difficulties and the stresses and circumstances associated with them. The student's background, including his family history, social history, previous adjustment problems, and school situation, is explored. Emphasis is placed on the student's feelings about himself and his relationship with others, including parents, peers, siblings, and teachers. Many other aspects of his development may be explored. Patterns of behavior, dynamics of symptoms and defense systems are studied, in order to arrive at a diagnosis and an evaluation of the strengths of the defenses and the severity of the pathology.

Many students, because of fear of the findings, the threat of exposure, or uncertainty

concerning their need for help, hesitate to consult a psychiatrist. For this reason, the student health physician, psychiatric social worker, psychologist, or nurse frequently sees the student first. Social workers are well-prepared to help the student through this initial period, and at the same time obtain much of the background and social information needed. They can help the student to determine his need for help, and to handle his concerns about having psychological and psychiatric evaluation.

The entire process of evaluation is carried out with strict adherence to the confidential nature of the disclosures. The student is told from the beginning that whatever he says and whatever is learned about him will be treated with respect and kept in confidence. If it is necessary to give reports to others, the student is told of these requirements as early as possible.

Many students do not require psychiatric treatment, even though the problem seems acute. Often the ventilation and support associated with the evaluative interviews will relieve the student's symptoms, at least temporarily. Accurate and careful evaluation may define the problem so that the student can work it out himself, or be guided to existing channels of help (chaplains, counselors, social agencies, and so forth).

In some instances, it may be more appropriate for the student to be encouraged to solve problems for himself for the sake of his emotional growth. Psychiatric and psychological evaluation will consider the student's strengths and ability to utilize resources available. Many students can be encouraged to alter their activities—academic, extracurricular and social—within the normal framework of the college in order to reduce stress and help themselves toward a better adjustment.

Where treatment is indicated, the goal, depth and type of treatment may be defined

by the psychiatrist. In many instances, short-term, limited goal therapy is all that is needed. Support over a longer time occasionally may be given by others (student health physician, psychiatric social worker, counselor, adviser or chaplain). If hospitalization or treatment by an internist, neurologist, or other medical specialist is indicated, the psychiatrist may help the student, his family, and the college health officials to decide on the best resource available. In other instances, the psychiatrist may provide psychotherapy or psychiatric management of the student on an out-patient basis.

Some students, especially those with acting out personality problems, may not be "treatable" in the college environment. In such cases the student must be tactfully informed of this decision, and the college administration must be apprised of the situation when they or other students may be involved.

The academic orientation should be maintained, and it should be thoroughly understood that the student is in college primarily to obtain an education. If his illness or disorder is too disturbing to others, excessively demanding of time and faculties, or presents a serious danger to the safety of himself and others, he should be removed from the college rather than expecting the college to make special arrangements for him.

THE VALUE OF A PSYCHOLOGICAL CONSULTANT TO THE STUDENT HEALTH PROGRAM

A psychological consultant can further the aims and goals of student health by helping to maintain and increase the student's enjoyment of college life and his efficiency in acquiring an education. The psychiatrist and his associates in mental health can assist the student health physicians in developing better health standards in the college and, by giving technical assistance in the manage-

ment of emotional needs and behavior problems, help them to minimize disruptive student behavior. From information gained during the evaluation of the students, psychiatrists can learn much about campus conditions and the effectiveness of available resources, and can therefore be of assistance to the administration and faculty in carrying out their responsibility to provide for the emotional needs of the students. In repeating such information, he should be extremely careful not to violate the confidence of any student whom he has seen professionally.

Let me emphasize here that the psychiatrist should serve only in an advisory and consultative capacity in relation to the administration, being ever aware that the student is enrolled in the college for educational purposes, which is the responsibility of the faculty and administration.

While the student health physician may be able to care for most of the emotional problems he sees, there are many instances in which a psychiatric evaluation will help him to define the type and extent of a disorder and will assist him in the treatment or disposition of the student. Many students will benefit from the evaluation alone, especially when its intent is primarily to help the student use his environment and his own resources to deal with his emotional problems and to continue his education effectively. The psychiatrist or psychologist, therefore, may save the time of the administrative staff, faculty members, the student health physician and other advisory personnel.

SUMMARY

Psychiatrists or, where they are not available, trained psychologists or psychiatric social workers may serve as consultants to the student health physician; they may see

and evaluate students referred to them from multiple sources; they may serve as consultants to the administration and faculty regarding appropriate admission and discharge problems and emotional problems of students; they may provide psychiatric treatment resources for students requiring

psychotherapy; and they may help students receive assistance through consultations with others. In addition to giving direct or indirect help to individual students, they can assist the college in providing a mentally healthy environment in which students can live, study, play, and mature.

A study in role diffusion: The chief and the sergeant face retirement

The stripes of the sergeant or chief petty officer—the *men who really run the service*—traditionally act as the exclamation points, the zenith of personal and often mythopoeic authority, for an enlisted, career serviceman destined to retire before obtaining commissioned officer rank. That they may also act as caesura to an otherwise chaotically unfolding personality is less apparent by customary yardsticks of personal mental health.

If we take this group's response to a common stress situation, impending or actual retirement (i.e. 1–2 years span), utilizing as additional buoys the sudden precipitation of psychosomatic, behavioral, psychoneurotic or psychotic reactions in his closest dependent (as perhaps the "weakest link" phenomena in a "family neurosis" [1, 2, 11] hitherto compensated);¹ we are confronted with the subgroup comprising the majority of referrals for psychotherapy² to

this psychiatrist at a general medical surgical hospital during the period January, 1961 to July, 1962.

There are mechanics of outpatient clinic referral which seem to skew the frequency curve of "mental illness" referrals toward

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The opinions expressed in this paper are solely those of the author and do not necessarily represent the official opinions of the U. S. Public Health Service.

¹ As T. S. Eliot observes in *The Cocktail Party*, "Indeed it is often the case that my patients are only pieces of a total situation which I have to explore. The single patient who is ill by himself is rather the exception."

² In contrast to consultation referrals requesting "aid in disposition," "aid in management," etc.

the chief: many potential NP problems have been previously winnowed out, some by the pyramidal competition for rank. Lower echelon personnel lack the relative autonomy and ease of mobility of the chief or sergeant who can make face-saving excuses for his absence and thus keep his psychiatric encounters from becoming base scuttlebutt. Officers frequently avail themselves of community psychiatrists for the same reason. The factors influencing hospitalization are less idiosyncratic, however.

A review of all admissions of Coast Guard chief petty officers to this hospital from

TABLE 1
Chi² Relationship Between Onset of Psychiatric Illness ("NP") in Coast Guard Chief Petty Officers and "Peri-retirement" Years
 (See above)

Admission for "NP" illness	Admission for other illness	Totals
Peri-retirement years (18-22 and 28-32)	1/61-7/62	T:41
32	9	
(average age 42)	(average age 42)	
Noncritical years	15	T:21†
6	(average age 34)§	
(average age 44)		
Totals	38*	24
		T-62‡

x² (with Yate's correction): 12.06 (Significant @ .1% level of probability)
 Of note are the following:

1. * Thus 61.3 per cent of this group were hospitalized for "NP" connected illness.
2. † These 21 men can serve as their own longitudinal control on the validity and reliability of the hypotheses contained herein.
3. ‡ These are 62 of the 70 chiefs admitted; sufficient data was lacking on the other eight. From all indications, they would make the significance even less explicable by chance.
4. § "T" test is significant at the .1 per cent level of probability with regard to the age of this subgroup. Other significant factors could not be isolated from the medical charts.

January, 1961, to July, 1962, revealed a marked, statistically significant incidence of onset of psychoneurotic, psychosomatic or psychotic symptomatology during what will be considered here as the critical "periretirement" years; i.e., 18-22 for those retiring after 20 years of active duty, 28-32 for those retiring after 30 years of active duty.

What follows as case presentations represents collages torn from the overlapping case histories provided by exploration of some aspects of the lives and personalities of the available family members in a combination of psychotherapeutic approaches: individual, group, family, conjoint sessions, etc. The margins of the question "Who is really the patient here?" will become blurred in the process. The range of psychopathologic response will emphasize the precipitating rather than causal features in the chief's or sergeant's retirement.

CASE I

Depressive Reaction with Suicidal Attempt

This Coast Guard chief petty officer was found in a semicomatose condition following ingestion of an overdose of sleeping pills. His wife emphasized the gradual deterioration in their relationship over the past two years, as he had begun to be preoccupied with concerns about his impending retirement (in about eight months). Diagnostically a "passive-dependent" individual, with much hysterical overlay (characterized in interviews by much sighing, blinking, and dramatic gestures), retirement posed for him "becoming a minnow instead of staying a whale."

His sense of generalized inadequacy was focused initially around concerns about being able to keep his wife, who was threatening to divorce him. This he blamed on his having made the service a career. However, he became aware of the conflicting wish to appease his father/mother-surrogate uncle who had raised him and who urged him to "go for 30 years" because "it is more secure." In this setting, acute anxiety symptoms of night terrors, and gradually increasing headaches and psychophysiological muscle reactions became apparent. His regressive, demanding at-

tempt to cope with the conflicts fed back into his relationship with his wife and family.

As his wife found their relationship deteriorating, she "dreaded his retirement, which would bring him into the house on a more continuous basis." As she withdrew into social activities and urged him to remain on isolated duty, he attempted to rally the family around himself—unfortunately at a time when his teen-age daughter's rebellious need to assert her independence led her to need to establish more distance from the family; e.g., she began to steal at school, leaving the evidence around. He reacted violently and beat her. Wife responded by taking daughter and suing for divorce. He then tried suicide.

CASE II

Psychogenic Backache, Stomach Ache, and Premature Ejaculation

A retired sergeant's wife entered treatment because of multiple phobias, compulsions, and a past history of alcoholism, bizarre somatic delusions, episodes of homosexuality, and frigidity. Considered to be a pseudoneurotic schizophrenic with many hysterical features, she became reasonably well-compensated while in supportive individual and group therapy, and while taking tranquilizers. Shortly thereafter, her husband came in for a conjoint meeting, at which time it was determined that the wife's symptoms were precipitated by his retirement from the army as sergeant two years earlier.

A tense and defensive, small and energetic man, he had been placed in a foster home following the death of his father when he was six. His two brothers, a sister, and a mother died shortly thereafter. The army indeed had "become his family" and his style of life. Active duty had separated him much of the time from his wife and had kept him from establishing a family life with her while in service. They had known each other on a relatively superficial basis through the six years of their marriage prior to his discharge from the service and both had rapid decompensations dating from that time. His premature ejaculations "started the day he took off the uniform," his back and stomach aches, soon thereafter.

CASE III

Acute Anxiety Attacks and Alcoholism

A Coast Guard chief in his nineteenth year of activity duty was transferred to a shore job of

largely administrative chores "until he retired." Acute anxiety symptoms (nightmares, feeling of suffocation, globus hystericus, numerous conversion reactions, tachycardia, sweating and sensations of falling) followed. Finding that alcohol in some ways relieved this symptom complex, his heavy social drinking increased to a point where he began to be absent from work, and led to his emergency hospitalization for alcoholic tremulosis.

His wife presented herself at the same time, with a drinking problem, headaches, panic state and multiple conversion reactions. During the eight months that the family have been in treatment, occasional contacts with their children revealed that their daughter has a problem about compulsive school habits, and their son "a learning block." It has become gradually apparent within this family that father's shift to a shore job markedly disturbs their usual state of equilibrium and, to quote his wife, "if he is like this now what will he be like when he retires."

His anxiety attacks and drunkenness shattered his esteem within the family; he became impotent, moved out of the wife's bedroom and attempted to assert his authority in the family by maintaining a stereotyped role of chief-as-authoritarian there. Increasing conflicts resulted; wife planned divorce but arranged psychiatric consultation for husband and self the day that he left home with his gun and was found drunk in a skidroad hotel room. His plans for retirement had been vague—"maybe I'll get some chickens and we will live without having to depend on anyone else"—and wife had become terror-stricken with financial worries and the thought of "having to put up with him all day."

CASE IV

Paranoid Reaction, Alcoholism and Peptic Ulcer

A Coast Guard chief in his last six months of active duty was admitted to the hospital drunk, depressed, suicidal and with recurrent ulcer symptomatology (complicated by some superimposed alcoholic gastritis). He was preoccupied with allegations about the infidelity of his wife and he had worked out numerous schemes for checking on her. A suicide attempt six months earlier had been accidentally discovered. He was convinced that even his service friends were against him and and that money that was meant for him was diverted elsewhere. Wife was found to be an attractive, masochistic hysteric with marked phobias

which would not allow her to stay in the same room with a clock or a calendar. Her provocative patterns precipitated sadistic responses in husband. Their only child was dying from a malignancy.

It became apparent that this man felt trapped between (1) remaining in the Coast Guard where he felt he belonged but could not check on his wife and (2) the overwhelming feeling of having no other roots, "no other personality," triggered-off by his impending retirement. Deep underlying identification of the Coast Guard and particular members of it with the mother and father he had never had (raised as an orphan and cared for in many foster homes) and the threatened loss stirred some hitherto successfully repressed homosexual concerns which were handled by paranoid projection onto wife.

Their usual sadomasochistic interaction had been enhanced initially by his increasing paranoid suspicions, but as his conviction of the reality of her affairs deepened, she became increasingly concerned for her life. As his violence erupted, she fled from his beatings and threats with a shotgun, into an ambivalent relationship with her own parents, retriggering her own oedipal conflicts around her father.

Husband openly wished son's death "so she can spend some time with me." In the setting of getting some of her own dependency needs fulfilled from a male therapist, wife was able to work through some of her ambivalent sexual fantasies towards her own father and could, in turn, support and "give" to her husband. A medical discharge was eventually effected because of the severity of his ulcer.

CASE V

Paroxysmal Auricular Tachycardia, Depression and Compulsive Drinking

This Coast Guard chief developed acute paroxysms of auricular tachycardia (4, 6) with accompanying anxiety and compulsive drinking six months prior to retirement. He had always regarded retirement as "one of those minor changes" and had expected no emotional upheaval. When his friends talked about their retirement and the challenge of the change after 20 years of Coast Guard life, he had scoffed, feeling that he was able to handle, without reaction, anything that minor. With the onset of his arrhythmia, however, the physicians at this hospital suggested he stop drinking and at this point he found himself

overwhelmed with gross feelings of inadequacy which became focused upon his inability to function as father to his psychopathic son, currently in a state penitentiary.

His mother accused him of being a bad father, and whereas he had been previously able to maintain a high level of denial toward his feelings in this regard, by maintaining a self-image of a hard-fisted, hard-drinking man, he suddenly found himself with acute anxiety attacks which began to trigger off his paroxysmal auricular tachycardia, a compelling need to drink and a general feeling of depression and failure, with thoughts of suicide and the conscious realization that his drinking pattern might bring him disciplinary action in the Coast Guard.

He rapidly became aware of the massive feelings of ambivalence he had about retirement. He explored the role changes and identity factors involved, as well as his general concerns about inadequacy. Symptomatic relief of his depression was followed by reports from his obese wife indicating that since his medical retirement (because of the recurrent attacks of paroxysmal auricular tachycardia on-board ship) he has been able to make steady progress in obtaining suitable work without lapsing into the demanding, petulant stages that so enraged her (10).

CASE VI

Hypochondriacal and Obsessive Reactions with Depression and Impotence

This 41-year-old Coast Guard chief had spent nine years at sea and expected to spend the six months prior to his retirement on shore. Instead, he was assigned under a new captain whom he felt was petty, lacking in common sense, and unusually gruff. He found himself increasingly irritated and angry at this man and began to experience preoccupying pains in different parts of his body, loss of appetite and insomnia.

After the captain commented that the run would bring them close to the Russian coast and, they had, therefore, better mount watch on their small anti-aircraft guns to ward off jet planes, he found himself increasingly preoccupied with even minor bodily processes and his general state of health. He began to have dreams of being attacked by rats. He reported to sick bay when he became obsessed about jumping overboard.

His previous service record had been spotless; his high degree of compulsivity had been channeled successfully into his service duties. When

the topic of his retirement had come up at home, prior to his last voyage, his wife had insisted that, with her ability to work, he needn't worry. His plans had been completely unformulated and, indeed, it developed that he had looked forward to the opportunity to discuss retirement plans on a personal basis with his new superior officer. He now found himself feeling he had no one to depend on and turn to for advice; he felt unable to handle his increasing rage.

Ventilation of this hostility was followed by rapid clearing of depressive symptomatology and he remained on active duty following a brief hospitalization. Throughout the month leading to his retirement, he was troubled by tension signs, stiff neck, impotence, preoccupation with bowel and bladder functioning; he needed constant reassurance that there was nothing physically wrong with his heart or other organs. As his retirement approached, he could ventilate his concerns about leaving the service.

Following firm, suppressive maneuvers, he made critical job plans and began to assert himself at home and work, his wife's ambivalent mothering attitude shifted, and his potency returned.

CASE VII

Tics, Duodenitis

As this chief approached his nineteenth year in the service, his wife began to demand that he plan his retirement in such a way that he could take an increasing responsibility for the management of their adolescent sons. In the year prior to this time, his beer-drinking had increased and two attacks of duodenitis had become apparent. His 17- and 15-year-old sons became involved at the same time in a series of thefts, window-breaking and curfew violations. Their acting out was followed by his wife's increasing her demands—"he should get out of the service and manage them."

Feeling trapped between his wish to remain in for 30 years and his conflict with his wife, his drinking increased, accompanied by numerous muscle spasms and a jerking tic of his head, accompanied by a pounding of his right hand into his genital region. Wife strenuously resisted his sexual overtures, using this as a lever in obtaining the job decision she wanted. He began to lose interest at work, accompanied by headaches, impotency and marked insomnia. His family was resistive to manipulative and therapeutic attempts; accordingly, it was considered highly likely that

environmental and familial problems would continue to be unmanageable.

His recurrent bouts of duodenitis and peptic ulcer appeared seriously to endanger his life, and medical discharge was therefore arranged. His current job does allow him to have some increased influence on his sons and there has been some improvement in his relationship with his wife. That much has really changed seems unlikely. He resists further therapy—"it takes something out of a man to have to depend on another one."

DISCUSSION

I wish to stress here that this paper approaches retirement as a crucial stress for these men—as a precipitating rather than a causal factor, leading to marked individual and family disorganization. Indeed, since most of these men and their families have been treated by "supportive" and "relationship" psychoanalytically-oriented psychotherapy (with much technical innovation along group therapy and child psychiatry family collaborative techniques, as defined by Levine (8), deeply unconscious material is rarely tapped. Thus, factors leading to clarification of the specificity of the individual's illness (2) may not be "engaged" during therapy. Although each of these cases has overdetermined roots, they appear to be reasonably understandable within the frame of reference suggested by Eric Erickson (5).

As he has pointed out, critical to successful voyage among the potential shoals of adolescence, is the gradual stabilizing of identity patterns in the face of role-diffusing tendencies. Each of these men had major crises early in life, predisposing towards a turbulent adolescence. Their chaotic and tenuous identification patterns of early life and major unresolved neurotic trends appeared to have rather readily disposed them toward finding within the service a life style, a strong feeling of personal identification which many readily admitted shaded over

into a feeling of "having a family for the first time."

Their self-image was "serviceman." Within the context of a circumscribed and reasonably structured life (despite the vicissitudes of war), those who went on to make a career of the service and reached the chief level had superimposed more exalted responsibilities and traditional imagery. At retirement, as one put it, they uniformly faced a plunge "from being the whale to being a minnow."

Erickson stresses the importance of a "moratorium" period to firmly work through one's identity problems. The relatively stable base of service life and roles may provide individuals with Harlow's terrycloth-mother type experiences—some exploration and maturation, but within limits. More readily, however, do service roles provide escape from the unconsciously determined individual conflicts; that is, a "pseudomoratorium." Inherent in the often-repeated "the service made a man out of me" of many chiefs, appears to be a feeling of ego integrity, which the statistics of this paper make seem temporary.

I would suggest that, to this group, retirement ends the pseudomoratorium. Robbed of the stable self-concepts engendered by service roles (7), they face anew the conscious and unconscious conflicts left unresolved from the preservice life.

In addition, Erickson's suggested critical developmental phases of adulthood—those of establishing "Intimacy vs. Isolation, Generativity vs. Self-Absorption and Integrity vs. Disgust and Despair"—are deeply complicated by their service lives. Most of these men face upon retirement:

... Adolescent, frequently rebellious children and frequently menopausal wives from whom they have often had prolonged separations. (One is impressed frequently with how these same separations have seemed the

only way that so "bad" a marriage could have compensated so well for so long);

... Jobs less responsible, creative, and demanding than the ones they have just left;

... A society faced with the uncertainties of war, automation, etc.;

... The unusual position of having retired; i.e., colloquially "being old," while still young.

The return of the chief or sergeant to "normal" society may trigger off tenuously compensated diadic (husband-wife or parent-child) or "triangular" relationships, conflicting unresolved developmental problems of each of the family members. At a time when environmental supports could be critical, the chaotic family situation is least equipped to provide this. (While it has been notable that supportive, family-oriented psychotherapy—at times "focal"—within these families can readily lead to what appear to be major readjustments within the family, accompanied by symptomatic relief, this appears to be beyond the scope of this paper.)

Conservative estimates place the value of each CPO to the service as better than \$75,000 each (10)—particularly during the last years of their service. We are dealing then with an expensively trained, elite group whose actual monetary, personal training, and supervisory value to their respective branch of the service is incalculable.

SUMMARY AND CONCLUSIONS

1. The stress of retirement (impending or actual) on the emotional stability of the Coast Guard chief petty officer (and comparable ranks in other services) is explored statistically and clinically. Illustrations are used to demonstrate problems of interlocking family neurotic problems, precipitated by the common stress—the retirement of the chief.

2. The concept of service life as a de-

developmental pseudomoratorium is explored.

3. The appearance of considerable homogeneity within this group will warrant further exploration. The potentials for preventive mental health efforts are largely unexplored at this time.

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Quo vadis I.Q.?

Some reflections on the current psychological scene

We have had two world wars, a tremendous growth of our population and a glacial shift from the farm to the city, from the South to the North, from the East to the West. Almost overnight, the social composition, the subculture and even the caste system of many districts in our cities have drastically changed.

We are now witnessing the "flowering" of the atom age and the beginning of the space age. There is a proliferation of many insightful theories about mental abilities. However, unlike the physical sciences, psychometric theory has outstripped our technology. Our individual intelligence tests are dated and hoary with age.

Our society intuitively understands that there is something amiss. The unquestioning acceptance of mental ability tests has

disappeared. Many an educator is becoming painfully aware of the fact that the helpfulness of the Binet (18), WISC (21), and the WAIS (22, 23), was exaggerated. They read psychological reports and ask, "Is this the child as we know him?" They indicate their concern over their charge and their misgiving that in the process of examination, the child who was tested was somehow left out of the picture.

It is about time the psychologist rethought some of his concepts and saw whether they fit in with reality. He will then find that there are many things amiss in the current clinical scene. There is, for instance, the need to abandon any unitary index of intelligence such as the I.Q. (19).

The abandonment of the time-hallowed concept of I.Q. will be an explicit recognition of the fact that we no longer view general intelligence as hereditarily determined and unitary. This step will also force a re-

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examination and possibly a redefinition and a refocusing on some of our other concepts. As a result of this, the profession will be able to adopt a functionally more adequate classification of intellectual abilities.

However, there will be many well-qualified psychologists who will take violent objections to the writer's reasons for forsaking the I.Q. concept. Among other issues this also raises a grave threat to the professional's ego. It means a most uncomfortable rethinking of the hypotheses upon which one's practice was based and also "an agonizing reappraisal" of one's functioning as a clinician.

One must know the historical background of intelligence testing in order to be able to understand the current cul-de-sac. Binet, who was one of the pioneers in mental measurement, was primarily interested in obtaining a diagnostic tool which would help him to diagnose more effectively and to differentiate between normal and mentally deficient children. He was aghast at the frequent misdiagnoses and unjustified commitment of children as mental defectives. He stressed a "valuable use of our scale will not be its application to the normal pupils, but rather to those of inferior grades of intelligence" (3). His original purpose was to "evaluate a level of intelligence" (3) and "not at all to establish or prepare a prognosis" (20).

Since comparatively little was then known regarding personality structure, psychodynamics or the laws of learning, Binet had to design his tests on a purely empirical basis. However, he was fully aware of how weak his theoretical bases were: "It is something far more complex that we measure" (10), and had some misgivings as to how his test might be used. He, therefore, stressed that "with practice, enthusiasm, and especially with method one can succeed

in increasing one's attention, memory and judgment, and in becoming literally more intelligent than before" (20).

Stern, another early test designer, was even more aware than Binet of the essential weakness of the tests and stressed that: "No series of tests, however skillfully selected it may be, does reach the innate intellectual endowment, stripped of all complications, but rather this endowment in conjunction with all the influences to which the examinee has been subjected up to the moment of the testing. And it is just these external influences that are different in the lower social classes" (10).

American psychologists were very much influenced at that time by Galton's hereditary theory and Darwin's theory of evolution (12). They were seeking for a tool which would help them to measure human abilities more adequately and enable them to prove that the unfolding human abilities, too, followed a lawful and predictable course. Binet's work was a godsend to them. Terman's psychometric innovation was to act on Stern's suggestion (15) and to adapt the I.Q. concept. Thus, practical recognition was given to the idea that the I.Q. was "constant" and that the intelligence test was a good predictive tool.

Kraepelin's influence was then paramount in psychopathology and his diagnoses also implied a prediction of a definite outcome. It was felt that mental illness was similar to physical disease. For instance, if a patient were diagnosed as having schizophrenia, the inevitable prognosis was dementia; if, by chance, such a patient recovered, it did not indicate that the therapy was successful but that originally there was a misdiagnosis.

The monumental error made by Terman and followed by lesser lights of the psychometric constellation was the implicit assumption that the quality of thinking, reac-

tion to reality, philosophy of life, nay the language itself, of the various socioeconomic groups in this country were the same. They thought that the groups differed merely in the fact that they had quantitatively varying amounts of the nebulous ability called intelligence.

What had to be done, therefore, was merely to secure a fair sample of this capacity in the general population and arrive at an average which would then be a good mental ability yardstick. If the sampling indicated that certain tests seemed to penalize underprivileged sections of the population, this only confirmed the validity of the tests involved.

The misgivings of Binet and Stern were thrown to the winds. Terman indicated "The results of five separate and distinct lines of inquiry based on the Stanford data agree in supporting the conclusion that the children of successful and cultured parents test higher than children from wretched and ignorant homes for the simple reason that their heredity is better." (17).

This was affirmed by the psychological exponent of the status quo, Goddard, who said, "Stated in its boldest form, our thesis is that the chief determiner of human conduct is a unitary mental process which we call intelligence—that this process is conditioned by a nervous mechanism which is in-born" (8).

The concept of I.Q. caught on like wild fire because it was in accord with the then-existing psychological climate of symptom and behavior pattern diagnosis. The I.Q. itself was considered diagnostic rather than symptomatic of a psychological state which needed further investigation.

This became rigidified in legal enactments and school policies. If the I.Q. was 69 it meant the child was mentally retarded and was either committable to an institution for mental defectives or could be assigned

to a class for mentally retarded. At any rate, he was hopeless and no psychotherapeutic intervention was possible. This therapeutic nihilism led to little or no work with the so-called feeble-minded. We still suffer from its after-effects (14).

During World War II many academic psychologists served in the army. The psychologist, because of his professional immaturity, lack of clinical acumen and search for acceptance as a member of the healing profession (quite a few of the psychologists were men who at one time aspired to become physicians) was quite willing to go along with the then-current psychiatric thinking and consider his tests in the category of psychiatric and/or medical diagnostic devices similar to X-ray or blood chemistry. He made inconclusive studies seeking to establish a relationship between psychiatric diagnoses, intelligence and psychometric patterns.

Released from the army, the clinical psychologist began to practice in schools, courts, and mental hygiene clinics. Alas, it was then that he found that the I.Q. tended to make more obscure rather than to clarify diagnostic problems! He would examine a child, administer an intelligence scale, find that the test was not a valid measure of the child's ability and write a report citing the I.Q. and explaining why it was not reliable. He further would explain at great length why the I.Q. was minimal and would supplement it with a well-supported psychodiagnostic profile.

Later, however, the hapless psychologist would learn that his qualifying phrases were not even read and that the judge or the school superintendent would dispose of the case on the basis of the numerical score. The remonstrances of the psychologist, who at this point began to feel like a charlatan, were of no avail. He was firmly told that

he either had to produce a number or look for another position.

A colleague of his, working in a mental hygiene clinic, also had his heartache. Faced with a crucial clinical problem where the determination of the precise mental level was most important in terms of diagnosis and proper disposition of the case, he found that in this no man's land the I.Q. was diagnostically ambiguous (11). The psychologist then took a close look at his tests and found that they were purely empirical, with little or no data regarding the theoretical preconceptions governing their design. If he examined the Wechsler Adult Intelligence Scale (22, 23) or the Stanford-Binet Intelligence Scale, Form L-M (18), he could note that by and large there had been no change either in test design or underlying theory.

The revisions of these tests did not show that any attention has been paid to the tremendous work done on test construction and test theory for the last 20 years. Hardly any new ideas have been employed in subtests, scoring, or scale organization. Most likely this may have been due to the fact that the test-makers felt that they were in a "strait jacket," inasmuch as they had to make provision for the derivation of a unidimensional index of intelligence; i.e., an I.Q.

To be sure, many prominent psychologists have called for caution in the use of I.Q.s (1, 6, 7). Some have called for the substitution of standard scores for I.Q. (23). However, this substitution of one term for another is not enough. The unscientific and unpsychological idea that general intelligence can be summed up in one magic number, whether it be called I.Q. or SD or percentile, would still be entertained.

Further, any index we substitute will soon assume the undesirable connotations of the I.Q. We must insist that in the

study of intelligence or adjustive behavior we must stress the "premise that intelligence is not an entity, nor even a dimension in a person, but rather an evaluation of a behavior sequence . . . from the point of view of its adaptive adequacy" (20).

This does not mean that one of our most potent tools (the various intelligence scales) are expendable. "There is immense need for subtle, personal, artistic skills in clinical practice, but when the clinician allows his artistry to be restricted to manipulating a test gadget, he is employing his skills at too low a level" (5). Because of the work of an army of brilliant psychologists, we have good tests, ground in psychometric theory. The clinician who is no longer I.Q.-bound will have an opportunity to sharpen his skills and become aware, to a greater extent, of minimal cues in diagnosis. It means that there will be greater need to learn how to integrate dynamically one's findings and to present this evaluative study to one's colleagues in the profession and to interested relatives and friends.

Understandably enough, this will disturb some of our practitioners who like to work in structured situations. "There are many individuals who long for the good old days of simplicity; when we got along with one unanalyzed intelligence. Simplicity certainly has its appeal" (9).

POSSIBLE CHANGES IN PSYCHOLOGICAL PRACTICE

The legal definition of mental deficiency in terms of I.Q. is similar to legal definitions of mental illness; e.g., insanity. Neither has any semblance to reality. Both are cumbersome, unworkable concepts, creating hardships for patients thus misdiagnosed.

Our abandonment of the I.Q. concept will necessitate a change in the laws of many states which indicate I.Q. limits,

within which one is eligible for commitment to institutions for mental defectives. Many state and city Boards of Education will have to abandon the rigid I.Q. scores they used for selection for the classes of intellectually gifted or mentally retarded.

I.Q. AS PREDICTOR

We have learned to look at our I.Q. as a valid predictor of intelligence and adaptive behavior both in school and society at large. When our expectations are not fulfilled, we do not say that the I.Q. is not a good predictor; rather, we explain things away by such factors as the emotional or physical state of the examiner or examinee, invalid administrations or unsuitability of the tests, which may account for the failure in prediction.

However, when many areas of intellectual development are validly and reliably measured, we should expect to find a change in them in accordance with life's experiences; we can then be more specific and predict that such and such a test under these specific experimental conditions for children of age X having Y personality traits in the Z subculture will give such and such results. If these predictions are not supported, a more careful examination of our hypotheses may be made to learn why the predicted change in the intellectual area did not occur.

On the basis of such a re-evaluation, we should be able to offer more valid criteria for a critical study of the intellectual growth or decline resulting from psychotherapy or acculturation, or changes in vocation, or varying self-concepts, or change with age.

NATURE-NURTURE CONTROVERSY

Possibly when we use multifactor tests of mental abilities, controversies re racial differences, nature-nurture, etc. will be seen

as an oversimplification of the experimental data.

TEST DESIGN

The test designer will no longer have to concern himself about whether he does or does not obtain a global rating on his tests which significantly correlates with the I.Q. on one of the popular scales. Nor will he be concerned that his subtests do not significantly intercorrelate. His main preoccupation will be with the fact that his subtests, disparate as they may be, do measure intellectual abilities which have both predictive and construct validity when applied to clinical situations.

The clinician will then no longer have to content himself with tests that "by definition are restricted to the simple, the piecemeal, the common, the over-learned" (16). Personality studies will be based more firmly on pattern analysis. Whatever differences are found will tend to be statistically significant, since they are based on factorial measures.

SCHOOL TESTING PROGRAMS

It will also bring about a change in school testing programs. The group intelligence tests are administered in schools because it is believed that they give a valid I.Q. predictive measure of future scholastic progress. However, it is well-known that including group intelligence tests in the educational achievement batteries does very little to increase prediction of scholastic standing (6).

With the mystique of I.Q. gone, there should not be too much difficulty for the schools in substituting measures of interest and personality for intelligence tests and combining them with the educational achievement tests. These will achieve the necessary educational goals such as class-

ification, grading, etc., without labeling, demeaning, or otherwise stigmatizing the child as being intellectually inferior.

SUMMARY

The historical origin of the I.Q. concept is discussed. It is pointed out that with the growth of psychometric theory, this concept is becoming less and less useful, both theoretically and in the clinical practice. A plea is made for the abandonment of any unidimensional index of intelligence. The legal, educational and clinical implications of such a change are examined.

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SYLVAN S. FURMAN, M.A.

A simplified approach to the promotion of vocational adjustment in mental patients

Over the past decade, the use of symptom-reducing drugs, revised concepts of mental hospital function and other factors have returned to the community increasing numbers of mental patients who require service from community agencies.

These agencies conduct a wide range of health and welfare programs, including outpatient psychiatric treatment, housing, recreation, vocational adjustment, financial assistance, etc. Some of their services may be given in connection with planned psychiatric rehabilitation programs, but patients also receive these services from agencies that serve the general population. Yet experience has shown that few American commu-

nities are well-prepared to cope comprehensively with the number and complexity of problems presented by former mental hospital patients, at least in ways that actively promote rehabilitation.

Simmons (9) and others have noted in follow-up studies that many hospital patients return to situations where they are "preserved like flies in amber," receiving from their families an equivalent of the custodial care they might have continued to receive as chronic patients in traditional mental hospitals. While permissiveness and acceptance are often present, there is too seldom any active, stimulating factor which can promote health and improve the patients' mental status, not to mention the battery of co-ordinated services often required for optimum assistance.

These deficiencies are due as much to the scarcity of professional personnel as to non-recognition of need, or to lack of funds.

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Blain (2) has pointed out that even with maximum promotion of training for the professions that collaborate in therapeutic and rehabilitative programs, in the foreseeable future there is little likelihood of our being able to supply sufficient personnel to cope directly with the total need, using present methods. Consequently, closer attention must be given to approaches which can meet at least the critical parts of patients' needs in ways that produce satisfactory total movement toward health.

Thus, if we are to simplify rehabilitation programs, both to increase effectiveness and to conserve personnel, it would seem reasonable to examine more closely the areas of functioning where patient adjustment is informally measured by the community, and to determine how this can be facilitated. Such examination might lead to ways of minimizing the investment of personnel and at the same time facilitating adjustment.

If it should be feasible to identify those critical environmental and experiential factors which of themselves tend to promote and advance rehabilitation, and to foster rehabilitation opportunities in relation to them, we might, in turn, be able to help rehabilitate more patients at less cost and without undue expansion of personnel.

WORK AS A REHABILITATIVE EXPERIENCE

In our culture, a high social value is placed on work. Considerable variation within and even outside the range of so-called normal behavior and personality traits will be tolerated by family, friends, neighbors and others who basically determine community adjustment—if an individual can be conveniently placed by his associates in a vocational niche. This establishes a place in our society for him, as almost nothing else can do.

Basic to successful job functioning is the

ability to report at a stated time to an assigned location, to respond to orders, carry them out in a productive way and to be worthy of some recompense in exchange for the work done. Work adjustment is a practical measure of community adjustment as well as a means to assist recovery from illness (5). Since there are many discharged patients who are not fully recovered and often are classified as "not amenable to psychotherapy," or for whom there is actually no further therapy available, work is an area which deserves special attention in planning economical and effective approaches to rehabilitation.

Dr. Arie Querido, the founder of the Amsterdam Municipal Psychiatric Service, establishes three requisite elements for a comprehensive program for post-care. They are: medical supervision, adequate housing and work. As reported by Lemkau and Crocetti (6), the goal is "realistic management in terms of community life." Accordingly, in the area of work, Querido defines the objective as "not permanent placement but keeping the patient employed as frequently and as long as possible."

American workers in the field of psychiatric rehabilitation have, of course, recognized the social value of work and have developed, in their own ways, vocationally-oriented programs for mental patients, with a variety of methods and goals. These may include work therapy, vocational retraining in schools and in realistic settings, sheltered workshops, supervised job placement in and out of hospital, and work-training programs either closely integrated with clinical service, or controlled and supervised by clinical personnel.

Examples are the programs of the Altro Health and Rehabilitation Services of New York (1); the Veterans Administration (7) in a number of cities; the Institute for the Crippled and Disabled (8); Vocational Ad-

justment Center of the Jewish Vocational Service, Chicago (3); South Carolina State Hospital (4) (one of a number of such programs in various states); and others. These programs have in common the presence and active participation, to varying degrees, of such professional personnel as psychiatrists, nurses, social workers, psychologists and specially-trained teachers and foremen. On the whole, within the limitations imposed by the patients' own status, such services appear to be rewarding in terms of skills learned, improved social adjustment and—an ultimate test—successful placement in open industry.

ANOTHER LEVEL OF PROGRAM

However, in addition to these approaches, which are especially valuable for patients who need close supervision, there would appear to be another level on which vocational rehabilitation could be inexpensively supplied. On this level the aim would be to meet the needs of a large number of patients whose main requirement is opportunity for exposure to realistic work tasks and settings, plus the satisfactions and recognition afforded by the social experience. In view of the values inherent in work itself, such opportunity would be of real benefit to patients, yet with minimum involvement of professional services in the work setting, or creation of special facilities.

To test these assumptions, the Manhattan Society for Mental Health in 1959 established in its own offices a work-experience or "job reconditioning" project for psychiatric patients. This project aimed at exposing ambulatory patients to a realistic office-work regime. The work consists of clerical and other office tasks ordinarily performed in carrying out the program of the agency.

(On a few occasions, the patients were

temporarily assigned on a similar basis to other community agencies; work was also "sent in" from other agencies.)

While there are professional personnel present in the office, the patients are not expected to relate to them in any way other than as members of the same staff. Patients are directly responsible to an office manager whose primary concerns are quantity and quality of production, rather than rehabilitation.

Referrals were invited from a local state hospital, an aftercare clinic, some hospital outpatient clinics, private practitioners and rehabilitation agencies. In each case, it was made clear to the patients and to the referring agencies that the latter were expected to continue service in accordance with their own functions, even in situations which might be handled more expeditiously by the professional personnel within the office. In other words, the presence of professional persons in the work setting was to be considered as irrelevant and coincidental.

The referring agencies were also informed that the work experience was to be viewed only as a phase of rehabilitation, during which, through his own efforts and the help of community agencies, the patient was expected to strive toward job placement in open industry, formal vocational retraining, or other more advanced goals. Patients were paid on a per diem basis—only enough to cover such working expenses as lunch and carfare.

The process of application and admission to the project was kept simple. In each case, there was preliminary discussion with the referring agency or referral source. During this discussion the reason for referral was learned, the purpose and limitations of the project explained and the continuing clinical responsibility of the referral source was emphasized. No

patients were accepted prior to a personal interview. During this interview the purpose of the placement was directly interpreted by the project director. Patients were expected to make their own appointments for the preliminary interview; on acceptance, they were assigned to the office manager.

RESULTS

Over a 22-month period, 32 patients were accepted. Two applicants were rejected because the referral source requested special conditions that were unrealistic in relation to the aims of the project. For example, a psychiatrist asked that a patient be permitted to paint and write poetry in the office, and a rehabilitation agency asked that a member of its staff temporarily accompany a patient and remain with her during working hours. An additional 12 patients were rejected for lack of work or of office space. (These figures are not considered to be indicative of the actual demand for placements.)

Two patients commuted to work from the state hospital; they eventually came home on convalescent status while continuing to work on the project. An additional 28 were admitted while on convalescent status, and two had never been hospitalized. In addition to the two patients referred directly from the hospital, there were 24 from the aftercare clinic, one

TABLE 1
Source of referral

State hospital	2
Rehabilitation agency	1
Aftercare clinic	24
Outpatient clinic	1
Private psychiatrist	4
Total	32

TABLE 2
Duration of contact with 27 terminated patients

Less than 1 week	5
1 to 4 weeks	9
5 to 20 weeks	8
21 to 52 weeks	3
53 to 78 weeks	2
Total	27

from a rehabilitation agency, one from an outpatient clinic and four from psychiatrists in private practice. (Table 1.) There were 10 men and 22 women.

The project deliberately refrained from detailed inquiry about patients' diagnoses and histories. Consequently, their clinical characteristics could not be tabulated. However, it was noted that the group was extremely varied. There was one drug addict, at least one alcoholic, a number of schizophrenics and a number of patients who had been in hospitals for long periods, one having been hospitalized continuously for 13 years.

There was a wide range of duration of contact with the patients. Five patients remained less than 1 week and 2 from 53 to 78 weeks. Seventeen remained from 1 to 20 weeks; 3 from 21 to 52 weeks; and 5 are continuing to date. (Table 2.)

Of the 27 patients who terminated, 8 obtained work in open industry; 3 went on to school or formal vocational training, aided by the state vocational rehabilitation program; 3 returned to the hospital; one terminated to carry out a personal plan; and 10 left for a variety of reasons, most of them negative. (Table 3.)

The last-named group included those who considered the work unsuitable, were bored, were distracted by home problems, were too disabled to work, etc. According to the referral sources, the 13 who left for

TABLE 3

Analysis of results (status at termination of contact)

Obtained work	8
Went to school or job training	5
Returned to hospital	3
Left because of personal plan	1
Left for miscellaneous reasons (work unsuitable, bored, serious friction at home, unable to sustain discipline of work, too disabled, etc.)	10
Continuing to date	5
Total	32

either work or school definitely benefited from the project. The other situations are less clear; the referral sources felt that most of them benefited as well, but this could not be objectively determined in terms of reasons for leaving or changes in behavior observed during the time span of their experience (5).

Some individual instances are worthy of brief mention. Two 19-year-old girls had completed a full course of vocational rehabilitation training in office work, but they could not find work for over three months after completing their courses. They were referred to the project by their psychiatrists to prevent regression resulting from the stress of unemployment. Both were admitted with the understanding that they would work afternoons only and seek regular jobs in the mornings. Both managed to get jobs after only two half-days on the project. In the opinion of the psychiatrists, the patients' experience with the project was sufficient to "trigger" a more positive and effective approach to job-seeking.

At another extreme, a 40-year-old male paranoid patient spent 78 weeks working full-time, occasionally exhibiting delusions of persecution and apparently developing a dependency on the service. However,

through his own efforts he eventually sought and obtained a suitable position, which he continues to hold. In view of the fact that none of the patients who obtained work or who went to school were considered ready to undertake such steps prior to referral, the experience may be considered as having been of real value to them.

Referring agencies and psychiatrists have stated that the project is being used by them for a variety of purposes: to prevent regression while awaiting employment or approval of training application; to resocialize patients; to remove them from disturbed family situations during the day and to keep them from harmful associations; to test the progress of therapy or to assess readiness for formal training.

In the experience of the project, it was possible to be of some aid to the clinical personnel of the referring agencies by transmitting information to them about patient behavior. Reports on progress or regression to the referral source were used to change clinical treatment or casework plans. For example, the re-emergence of psychotic symptoms in one patient led to brief rehospitalization; later, he was readmitted to the project.

In a few instances, medication was adjusted on the basis of the reports on behavior. On several occasions, patients sought counseling from agency staff about personal problems. The staff, while avoiding the appearance of rejection, suggested that help be sought from the referring psychiatrist, social worker or nurse.

HAZARDS AND SAFEGUARDS

In appraising the project experience from the standpoint of problems for the "host" agency, as well as possible hazards to the patients, there are several points to be noted. One is the danger of exploiting

patients by using them as a source of cheap labor. In a few instances, when the patient seemed to have gained optimum benefit from the experience, the referral source was notified and plans were made to continue his total rehabilitation plan elsewhere.

Administratively speaking, there was sometimes a temptation to retain patients with good work productivity and to reject those who were less efficient. On the other hand, a tendency was observed for some referral sources to view the project as a custodial facility solely to keep patients out of mischief, or to relieve their families of their presence during the day.

While not necessarily 'destructive' in themselves, these were not considered to be vocational goals, but rather as goals potentially demoralizing to the other patients or to the program. Another hazard is loss of the agency's own efficiency because of over-accommodation to patients' needs. This can also have the effect of diluting the "real-life" aspects of the experience for the patients. Such hazards can be controlled by clearly establishing and reinforcing with the staff, patients and referral agencies, the terms of the patients' stay at the agency.

APPRAISAL OF THE METHOD

On the basis of the experience of both the project agency and the referral sources, an approach to vocational rehabilitation on this level would seem to be of potential benefit to a larger number of patients than can be reached through more elaborate methods. While the latter approaches are indispensable for certain classes of patients, our experience indicated that there evidently are additional numbers who can benefit from simpler, less expensive service, provided the sources of referral continue to maintain their ordinary clinical

responsibilities and a co-operative, supportive attitude.

It is further believed that because of its flexibility and simplicity, this type of service can be duplicated in a variety of settings, thereby increasing community resources. In addition to nonprofit community agencies, commerce and industry should be considered as locales for experimentation in such work. Certain experiences along related lines by community agencies with private industry in San Francisco and New York would appear to substantiate this.¹

Fundamental to the success of such projects, however, are clarity as to aims and limitations of the service; careful interpretation of goals and terms of each placement to patients, referral sources and those who comprise the project setting; and care to avoid or minimize the hazards previously mentioned.

The expansion of such projects in a community will depend, to a considerable degree, on the community organization skill of the promoting agency or agencies, and the dedication of the laymen involved as project sponsors. In addition to the benefits to the patients as individuals, it is believed that successful operation of such projects can bring about an expansion of vocational rehabilitation, a reduction in rehospitalization costs, and greater public acceptance of mental patients through experience in ordinary contacts.

SUMMARY

In summary, it has been reported that over a 22-month period, a group of 32 convalescent mental patients were given work experiences in a realistic office setting un-

¹ San Francisco Association for Mental Health, Employment Planning Committee for Psychiatric Patients, and Foundation House Foundation, New York City.

der normal supervision, with clinical responsibility remaining with the referral source. Of the 27 whose experience has been completed, 13 left to take jobs or formal training (one to complete a personal plan); 3 returned to hospital; and 10 left for miscellaneous reasons. Referral sources have evaluated their experience positively. Various hazards and safeguards, as well as the values of the project, have been discussed.

Expansion of this kind of work seems indicated in order to conserve scarce professional personnel, reduce costs of rehabilitation and rehospitalization, to serve as a means of promoting community acceptance of rehabilitative work for mental patients, and to provide patients with a real-life experience that can serve as a bridge toward a better total community adjustment.

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Employer attitudes, discharged patients and job durability

A growing body of empirical evidence supports the hypothesis that the attitudes of employers are important elements affecting the vocational future of patients discharged from mental hospitals (3, 4, 8, 9).

Many discharged patients face not only the task of finding suitable employment, but also of accommodating themselves to innumerable social and technical pressures of the jobs they take. Navran's (6) findings clearly suggest that subsequent success or failure in remaining on the job is conditioned by situational factors existing independently of the personality dynamics of the patient. Such factors include the employer's readiness to tolerate mistakes by the employee, the imagined effects of mental illness on competence and reliability and how the employee's performance is evaluated against the importance attributed to the job by the employer.

The main purpose of this study is to

determine the effect these employer attitudes may exert upon the discharged patient's duration of employment on a given job. The guiding hypothesis is that intolerant, unfavorable attitudes toward mental illness and its associated, residual manifestations among expatients will tend toward early dismissal or resignation.

Evidence presented below supports this hypothesis. Expatient employees working for employers holding favorable attitudes, as measured by appropriate attitude items, tend to remain on the job longer than those working for unfavorably oriented employers. This finding may be regarded as a logical extension of the effects embodied in the concept of employer receptivity in-

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troduced by Olshansky (7) and Landy and Griffin (3) in their studies of factors influencing placement of discharged patients.

The expatient status not only hampers an applicant's chances for initial employment, but its unfavorable properties continue to operate in the employer's evaluation of job performance after hiring the former patient. Apparently, some employers are unduly sensitive to the behavior of employees with histories of mental illness and are thereby predisposed to detect and exaggerate evidence of job mistakes.

RESEARCH PROCEDURE

Attitude Scales

Two sets of attitude items have been assembled on the assumption that employer receptivity may be subdivided into two empirically distinct, though related dimensions. One is concerned with the question, "How much does it matter to employers whether an employee is a discharged patient?" The relevant attitude items are intended to furnish an indication of the employer's perception of the expatient status in the context of the job and to reveal any preconceived notions of unfit-ness attributed to that status.

As Olshansky (8) has observed, such preconceptions have the same sociological significance as those imputed to other socially disfavored minorities; i.e., perceived attributes of the individual are influenced by the presumed personal qualities customarily associated with status labels. Such items afford a means of approximating the possible effects the status image of mental illness may exert upon the employer's behavior toward the expatient employee.

The second dimension of employer receptivity is concerned with the question, "How much do employers vary in their tolerance of behaviors which are usually deemed inappropriate, unwarranted or

undesirable on the job?" Since most discharged patients carry residual symptoms of their mental disorders into situations outside the hospital, it is plausible to suppose that varying degrees of interpersonal disharmony or other unwelcome intrusions are destined to interfere with job performance. Such complications are almost certain to occur even among employees who have never undergone hospitalization.

Equally as certain is the fact that employers will detect and pass judgment on these intrusive behaviors, whether they are aware of their connection with mental illness or not. In view of the fact that most discharged patients conceal their hospital experience (3, 7) from prospective employers, the latter would necessarily formulate opinions of such inappropriate actions independently of their origin in a mental illness. Here, then, is the principal reason for the distinction between status and performance. The discharged patient may be able to conceal his hospitalization, but he cannot conceal his maladaptive behaviors on the job.

It is important, therefore, to assess employer attitudes toward these attenuated symptoms of behavior pathology, regardless of origin and independently of the employer's cognizance of the employee's clinical history. Accordingly, a scale consisting of 18 items (see Table 3) describing various maladaptive actions by employees was administered, with instructions to rate each one according to its degree of seriousness.

Subjects

The subjects of this research are 100 they were known to have hired discharged patients, wittingly or not. The interview results show that 54 of them were cognizant of their employees' hospitalization. The remaining 46 employers were either un-

aware or unwilling to disclose such information. Names and addresses of employers employers deliberately selected because were procured from records of the state hospital, the regional Office of Vocational Rehabilitation and from personal interrogation of discharged patients who were asked where, for whom, and how long they worked since release.

Employers were apprised neither of the reasons for the study nor that they had been singled out for investigative attention because they had hired former patients. In 61 cases the expatient employee was no longer working for the employer. The average length of time out of the hospital was 22 months. All patients used in making employer identification were diagnosed as having schizophrenic or affective disorders.

The length of time the patient remained with a given employer was recorded for subsequent analysis, along with responses to attitude questions. Job duration has been selected as the principal criterion for assessing the impact of employer beliefs and attitudes on the discharged patient's vocational adjustment. It has been quantified by assigning to each employer a score corresponding to the number of months the expatient remained employed. The median of the resulting distribution breaks evenly between eight and nine months, conveniently providing two groups for comparison: (a) the short-term employers whose present or past expatient employees worked eight months or less and; (b) the long-term employers whose present or past employees worked nine months or longer.

Criterion

The proposal to use this criterion for assessing the impact of attitudes upon an employer's behavior toward discharged patient

employees raises a number of methodological questions which deserve further consideration. The hypothesis of this research asserts that intolerant or other stressful behavior stemming from the employer's unfavorable attitudes prematurely terminates employment, either because of the employee's consequent personal dissatisfaction or outright dismissal.

Obviously, many factors other than the employer's attitudes contribute to the time a person remains on a given job. Finding more remunerative or congenial jobs, seasonal variation in labor requirements, illness and incompetence readily come to mind. These extraneous factors would necessarily introduce irrelevant variance in the criterion and diminish its sensitivity as an instrument of detection. Thus, even if the hypothesis were true, the results might fail to support it.

Equally as serious is the possibility that these extraneous factors generate attitude variations consistent with the hypothesis, thereby leading to spurious, causal inferences. With the data at hand, this alternate explanation can neither be proved nor disproved. However, for what it is worth, the two groups of employers are compared in Table 1 with respect to number of employees under their supervision, layoffs occasioned by insufficient business, new employees hired each year, education, and types of jobs held by their expatient employees.

Differences associated with the first three factors are clearly negligible, while the latter are open to inconclusive interpretations. Short-term employers are somewhat less educated, tend to make more dismissals, have more expatient employees in clerical and unskilled jobs and fewer in sales, skilled and semiskilled jobs. That the short-term employers have lower educational attainment is presumptive evidence favoring the hypothesis, in view of the widely known

TABLE 1

*Number of Short- and Long-Term
Employers with Various
Characteristics*

Characteristics	Short-Term	Long-Term
Number of employees working for employer		
0-5	8	7
4-5	12	5
6-19	13	23
20-up	17	15
Employees laid off by employer in preceding year		
None	43	45
1 or more	7	5
New employees hired each year		
0-5	30	30
6-15	12	9
16-up	8	11
Number of employees dismissed during past year		
None	18	24
1 or more	32	26
Education of employers		
0-11	15	10
12-14	20	13
15-up	15	27
Patient's job classification *		
Clerical	18	6
Sales	4	18
Skilled and semi-skilled	10	16
Unskilled	18	10

* The specific occupations of the employees subsumed under these categories are as follows: *Clerical*—all secretarial, stenographic positions, bank tellers, bookkeepers, draftsmen, loan clerks and cashiers; *Sales*—automobile, department store, trading stamp store, clothing store, bookstore, paint shop, lumber company and hardware; *Skilled and semiskilled*—truck drivers, plumbers, radio repairmen, sausage makers, weavers, machine operators, piano tuners, auto mechanics, police dispatchers, typewriter repairmen, telephone lineamen, carpenters, machine accounting operatives; *Unskilled*—dishwashers, counter girls, parking lot attendants, stock clerks, food handlers, janitors, hospital aides, gas station attendants, porters, car wash attendants, kitchen helpers, yardboys.

correlation between education and social attitudes toward the mentally ill.

Still further support is suggested by the coexistence of this relationship with a slightly higher rate of dismissals, part of which might be attributable to intolerant attitudes toward the employee's performance. Less intelligible, however, is the meaning of the fact that more unskilled and clerical employees work for the short-term employers and that more skilled, semi-skilled and sales persons work for the long-term employer.

One implication is that assignment to either side of the criterion is an artifact of what might be normally different mobility rates associated with job openings between the industries in which employers are engaged.

Prevailing interfusions of lower education, unskilled job openings and high employee turnover rates would contaminate the criterion and reflect clusterings of cultural factors between types of industry rather than attitude variations between employers. However, the fact that the general turnover rate among the short- and long-term employers is roughly the same (see line 3 of Table 1) warrants the belief that there is enough unexplained variance to justify using duration of employment as a conditional criterion. With due recognition of these limitations, the following paragraphs set forth the more salient results of this inquiry.

FINDINGS

Status Perceptions

The decision to hire an applicant is usually the end product of a review of various items of evidence which may include age, sex, marital status, education, previous experience, etc. An applicant's status as a former patient, therefore, becomes another

item of interest affecting the decision. Some idea of the degree to which this status influences the employer's behavior may be approximated by considering the responses to the scale items shown in Table 2.

Most employers are interested in knowing whether a prospective employe has had a mental illness. Nine out of 10 would want to know about an applicant's hospitalization before employment. Long-term employers are somewhat less concerned with this information than the short-term employers. Four out of five employers affirm the belief that discharged patients will do as well on a given job as other persons with similar qualifications.

Replies to this question are more favorable than to any other item in the scale, possibly because the question wording does

not require the respondent to think of the expatient in the context of his own business. Fewer short-term employers believe expatients will perform as well as anyone else with the same qualifications. Although the difference between the two groups of employers on this question does not depart significantly from chance expectancy, it is in the hypothesized direction.

The proportion of favorable replies drops noticeably when employers are asked whether a recovered mental patient can be trusted on a job as well as anyone else. The concepts of trust and performance obviously mean different things to some employers. In this instance, the distinction implies that even though the expatient may perform satisfactorily, he cannot necessarily be trusted as well as others.

TABLE 2
Responses of Long- and Short-Term Employers to Attitude Questions About Discharged Patients

Question		YES		
		Long	Short	Total
1. If a man had been a patient in a mental hospital at some time in the past five years, would you want to know about it before hiring him?	N	43	47	90
	%	86	94	90
2. Expatients will do about as well on a job as anyone else with the same qualifications.	N	42	37	79
	%	84	74	79
3. Do you think a person who has recovered from a mental disease can be trusted on the job as well as anyone else?	N	34	26	60
	%	68	52	60
4. If you had one opening and two job applicants of equal skill, experience, etc., and one was an ex-mental patient and the other was not, would you hire the patient?	N	19	14	33
	%	38	28	33
5. Would you just as soon hire a person who had been in a mental hospital as anyone else?	N	24	14	38 *
	%	48	28	38
6. Most employers would prefer to hire people who have never been mentally ill.	N	42	49	91
	%	84	98	91
7. Should employers go out of their way to give jobs to people who have recovered from a mental illness?	N	26	29	55
	%	52	58	55
8. People who have been in mental hospitals will try to hide it from their prospective employers when asking for a job.	N	29	39	68 **
	%	58	78	68

* $X^2=4.29$ $P<.05$.

** $X^2=4.60$ $P<.05$.

In turn is the implied tendency to deny jobs to discharged patients where trustworthiness is regarded as an important consideration, or to become conspicuously vigilant in the supervision of expatients to whom jobs have been given. That this distrust may provoke dissatisfaction and possibly alienation between employee and employer and thereby abbreviate an otherwise longer period of employment is suggested by the fact that short-term employers are less inclined to affirm the reliability of such employees.

It is also worth noting that the short-term employers are significantly more disposed to believe that discharged patients attempt to conceal their illness when seeking jobs. Although the correctness of this opinion is supported by Olshansky's findings, it is doubtful whether empirical knowledge accounts for the difference between the two groups of employers.

In this case it seems likely that the imputation of concealment arises from the more unfavorable image of mental illness held by these employers. Further evidence of the possible impact of this unfavorable image is reflected in the fact that 98 per cent of the short-term and 84 per cent of the long-term employers impute to other employers a desire to avoid hiring persons with previous illness.

An aura of distrust also seems to influence employers facing an option between two applicants, equal in all respects save a history of mental illness. Two out of three would not hire the expatient. This figure is patently less favorable than that reported

by Olshansky, *et al.*, (8) indicating that 75 per cent of the employers in their sample would hire discharged patients. Question wording undoubtedly accounts for a sizable part of the difference. It is one thing to ask an employer if he would hire an expatient and quite another to ask if he would take an expatient over one of equal competence lacking that handicap. The latter invites unfavorable responses by placing the employer in the uncomfortable position of needlessly risking real or imagined complications by selecting the expatient.*

Yet, almost two out of three employers also say "No" when asked the more general question, "Would you just as soon hire a person who had been in a mental hospital as anyone else?" This is another way of asking if the expatient status makes a difference to employers. That it plainly makes a difference for the majority of those studied indicates vocational disadvantages for expatients seeking or holding jobs in competition with persons free from previous afflictions. One disadvantage is the possibility of subsequently losing or quitting the job, as suggested by the fact that fewer short-term employers would hire expatients than would the long-term employers.

The unmistakable incongruity apparent in the fact that all the employers in this study had hired discharged patients (with 54 per cent knowing it) may blur the practical significance of these attitudes, but it also suggests compromise and retrenchment among employers seeking to fill unpopular vacancies. An unanticipated outcome of these presumably reluctant concessions is the likelihood of vocational dissatisfaction, resignation or discharge as evidenced by the uniformly more unfavorable attitudes of the short-term employers.

This outcome is logically consistent with predictions implicit in Festinger's (1) theory of cognitive dissonance and Heider's (2) the-

* Olshansky's question ostensibly asked employers if they would hire expatients without further qualification. This would allow a wider latitude of conceivable circumstances which, in the employer's opinion, might justify such employment, thereby inflating the number of "yes" answers from many otherwise unfavorably oriented respondents.

ory of perceptual balance. Both involve the postulate that discrepancies between cognitions, attitudes and behavior will produce changes tending to restore a state of balance or consonance among the components.

Thus, combining a negative attitude (e.g., toward mental illness) with a positive act (e.g., hiring expatients) creates a condition of dissonance which may be resolved either by a transformation of the attitude or else by realignment of the behavior with that attitude. In this case, the negatively oriented employer who hires an expatient either develops a new and more favorable conception of that person or else his behavior reconverges with the attitude to the disadvantage of the expatient employee.

This inference becomes all the more plausible when the 54 undeceived employers are singled out for separate analysis. Twelve of the twenty-six long-term employers who knew of their employees' previous illness select the expatient when confronted with an option between the two applicants. Only six of the twenty-eight short-term employers make this selection.

As to the amount of association between acceptance indicated in this question and duration of employment, an estimate is provided by computing a tetrachoric correlation coefficient. The resulting value of r is .42 ($P < .05$). When the same measure is computed for those employers who are unaware of their employees' previous illness, the resulting value of r is $-.11$ ($P < .50$). Again, the conclusion appears warranted that the expatient status adversely affects the employee's chances for uninterrupted adjustment to the job.

Employer Tolerance

The 18 items shown in Table 3 constitute an *ad hoc* scale for measuring employers' tolerance of annoying, unwelcome and ir-

regular behavior on the job. Underlying the use of these items is the assumption that they represent a sample of a larger spectrum of employee actions which may infringe in different degrees on the employer's tolerance limits, and that unfavorable attitudes toward the sampled behaviors reflect similar attitudes toward other vocationally undesirable actions not included in the scale. Assuming that many of the expatients used to identify the subjects of this research probably exhibited varying degrees of disapproved and maladaptive acts on the job, this scale may be used as a tentative measure for testing the hypothesis that employer attitudes toward such behavior influence duration of employment.

Employers rated all items on a 4-point scale ranging from "Wouldn't matter" to "Unfit and undesirable." Arbitrary weights of 1, 2, 3 and 4 were assigned to the response categories and item means computed for both groups of employers. With two exceptions, all differences between items are in the hypothesized direction. Long-term employers are somewhat more tolerant of deviant behavior than short-term employers. Since only six of the items meet the customary confidence level, summation scores were computed for each employer, based on the sum of the weighted tolerance ratings for all 18 items. The resulting means are 54.0 and 50.8 for the short- and long-term groups, respectively. For a one-tailed test of significance, justified with a directional hypothesis, the value of " t " is 1.83 ($p < .05$).

An examination of the individual items composing this scale suggests a number of clues which may contribute to our understanding of the employers' attitudes toward undesirable behavior on the job. The items shown in the table have been arranged in a rank order from most to least serious, based on the individual item means. As might be expected, the most unsavory offenses are

TABLE 3
*Distribution of Short- and Long-Term Employer Responses to
 Undesirable Employee Actions by Number,
 Item Means and "t" Test Values*

How would you judge an employee who:	Wouldn't matter		Poor but acceptable		Be tempted to fire him		Unfit and un- desirable		\bar{X}		†
	S*	L*	S	L	S	L	S	L	S	L	
1. Drinks on the job	0	1	1	2	2	2	47	45	3.92	3.82	1.03
2. Provokes trouble with the police	0	1	0	2	1	8	49	39	3.98	3.70	2.95
3. Speaks rudely to his superiors	0	1	2	7	7	13	41	29	3.78	3.40	2.81
4. Causes bad feelings among coworkers	0	1	7	2	10	15	33	32	3.52	3.56	.28
5. Doesn't like his job	0	3	7	7	10	9	33	31	3.52	3.36	.95
6. Often confused in thinking on and off the job	1	2	17	16	8	13	24	19	3.10	2.98	.63
7. Has attempted suicide	6	9	12	13	3	4	29	24	3.10	2.86	1.02
8. Always distrusts people	1	2	20	19	9	8	20	21	2.96	2.96	.00
9. Is late for work twice a week	1	2	16	27	16	10	17	11	2.98	2.60	2.17
10. Cries over minor incidents	2	4	18	20	14	10	16	16	2.88	2.76	.63
11. Makes a poor impression on people	4	6	18	21	8	9	20	14	2.88	2.60	1.35
12. Believes everyone dislikes him	5	6	22	28	6	8	17	8	2.70	2.36	1.78
13. Is often sad and unhappy	3	3	25	25	7	10	15	12	2.68	2.62	.32
14. Keeps to himself, avoids others	5	15	20	20	7	4	18	11	2.76	2.22	2.48
15. Is an exconvict	15	24	14	17	1	0	20	9	2.52	1.88	2.67
16. Speaks unfavorably about religion	15	9	12	31	6	2	17	8	2.50	2.18	1.46
17. Is easily excitable on the job	5	8	38	32	4	4	3	6	2.10	2.16	.40
18. Has many family problems	8	12	35	28	1	5	6	5	2.10	2.06	.23

* The symbols S and L, respectively, designate short- and long-term employers.

† For a one-tailed test, values of t higher than 1.68 $p < .05$; values higher than 1.99 $p < .01$.

drinking and provoking trouble with the police, both of which are normative deviations distinguished by high social visibility and widespread disapproval.

Even if such conduct did not result in pecuniary loss, employers could ill-afford to look lightly upon this unpopular and unapproved behavior. The overwhelming majority regards it as unfit and undesirable. While both groups are about equal in their disapprobation of drinking, the employers whose expatients employees worked continuously for long periods are noticeably more tolerant and presumably more humanitarian toward employees who incite disturbances leading to police intervention.

The next four behaviors listed in the

scale—defiance of authority, causing ill will among coworkers, dislike of the job and cognitive confusion—are matters of serious concern to employers. Relative to the remaining offenses, these acts tend to be more conspicuous intrusions upon work routines, threaten pecuniary loss and diminished productivity. A common feature of these four items is a direct connection between job performance and disruptive actions.

Only two other items in the scale explicitly associate the job with undesirable behavior. Being late for work and excitability on the job, ranked ninth and seventeenth, respectively. Of all six behaviors, impudence and tardiness discriminate most significantly between the long- and short-

term groups. Both differences suggest overtones of the authoritarian personality among the latter, which may well generate an unfavorable vocational atmosphere for the expatient employee. The inflexible, norm-bound employer may find it difficult to comprehend or accommodate himself to the unsteady and possibly blunted performance of the discharged patient.

With the exception of items 15 and 16, the remaining behaviors involve personality problems which are less explicit in their relevance to the job, thereby allowing respondents wider latitude in imagining the effects which such symptoms may exert upon the employee's performance. From the employer's perspective, the more unsatisfactory and possibly more threatening of these symptoms are habitual distrust of others, tearful outbursts, attempted suicide and making a poor impression on others. Of these symptoms, only the latter two sharply differentiate the two groups of employers.

More acceptable to both groups are acts indicating depression, a sense of personal rejection, social withdrawal and family problems. However, the short-term employers are patently less tolerant of employees exhibiting social withdrawal and a sense of personal rejection. Since both are symptoms of diminished sociability, the capacity to mix freely with others on the job is of greater importance to the short- than the long-term employers.

Most of the symptoms described in the foregoing paragraph are typically more prevalent, not only among the kinds of expatients used to identify employers of this research, but also among a sizable proportion of patients discharged from all state hospitals. They are the symptoms which tend to characterize persons who have had schizophrenic and depressive disorders. That employers are conspicuously more lenient in their attitudes toward these symp-

toms than the less common but more spectacular deviations such as drinking, defiance of authority and provoking ill-feelings on the job, bids fair for this type of expatient.

Finally, the two items referring to the ex-convict status and speaking unfavorably about religion deserve comment. Both represent visible departures from the mores and tend to be normative as opposed to situational deviations. Both significantly discriminate between the two groups of employers. Again, the short-term employers are distinguished by a greater penchant for stigmatizing unconventional behavior. They differ from the long-term employers by their disposition to ascribe more emphasis to normative deviations than to actions indicative of such situational interruptions as depression, tearful outbreaks, confusion and excitability. Such differences lend further support to the hypothesis that normative inflexibility is one of the factors contributing to vocational stress and discontinuity.

It is noteworthy that, compared to other items in the scale, neither of these deviations is a matter of inordinate concern to most employers. The majority remain apparently unmoved by the odium so often associated with the exconvict status in popular thought. Only 29 of the 100 employers regard it as unfit, while 31 say it is poor but acceptable, and 39 look upon it with indifference. It is surprisingly innocuous by comparison with disliking the job, impudence to superiors and attempted suicide—collectively disapproved by two out of three employers.

CONCLUSIONS

Previous studies have stressed employer attitudes as significant factors in the occupational placement of the discharged and still recovering mental patient. The present research goes a step further to determine whether these attitudes diminish the ex-

patient's chances for staying with the job. Although uninterrupted employment is hardly a virtue per se, the mental health of discharged patients necessarily presupposes a certain measure of job continuity.

This research has adduced evidence tentatively supporting the hypothesis that vocational discontinuities tend to be multiplied as a result of the unfavorable properties of employer attitudes toward the expatient status and various residual symptoms of mental illness.

Olshansky, *et al.*, (8) have correctly observed that expatients escape stereotyping by employers through concealment. However, the fact that attitudes toward symptomatic residues are associated with duration of employment tends to cancel much of the advantage gained from the practice of concealment to which most expatients subscribe. Expatients who succeed in concealing their illness are unlikely to avert the unwanted consequences of maladaptive symptoms carried over to the job. These residues often invite unwelcome disfavor with the employer, whether or not he is aware of their clinical origin. This conclusion obviously reaffirms the value of interpreting symptomatic deviations to employers in educational and placement procedures aimed at cultivating greater receptivity toward prospective expatient employees.

Vocational rehabilitation officials are no doubt aware of the insufficiency of merely finding the expatient a job and that steps are necessary to assure some degree of job continuity. Accordingly, they might find some practical value in the meaning of the rank order of seriousness of symptoms rated by the employers in this study. At least one implication is the task of maximizing congruence between the patient's symptoms and the employer's conceptions of tolerable job behavior. This necessarily requires an evaluation of the patient's most probable

symptomatic deviations against the individual employer's receptivity to such behavior.

In a recent study which describes a number of perceived weaknesses reported by employers of discharged patients, Margolin (5) optimistically recommends, but questions, the practicability of rehabilitative procedures to eliminate the vocationally undesirable symptoms of which employers complain. Granting the limitations acknowledged by Margolin, a tentative solution might be worked out by recognizing that in the majority of cases only certain symptoms demand rehabilitative attention.

As indicated earlier, symptomatic deviations most likely to alarm the employer are those which threaten to unsettle job routines, invite needlessly bad publicity or diminish productivity. By contrast, symptoms of withdrawal, personal rejection and having serious family problems are more readily suggestive of illness *qua* illness and are more acceptable to employers. Even these symptoms, however, may be matters of serious concern to employers with authoritarian attitudes. In such cases, needless vocational dissatisfaction and maladjustment are readily circumvented by looking elsewhere for placement opportunities.

Finally, it is fitting to reiterate certain limitations of the research. It has only examined and discovered attitude differences between two groups of employers classified according to the length of time expatient employees remained on the job. Accordingly, the conclusions reached here do not rest on evidence of reciprocal evaluations between specific employers vis à vis specific expatient employees.

Lacking such information we are unable to determine the extent to which firsthand contact with expatient employees generates negative employer attitudes, nor how much these attitudes contribute to the individual

employee's subsequent dissatisfaction with the job. New plans are being formulated to remedy these limitations by investigating the expatient employee's perceptions of his present and past employers and to make appropriate comparisons.

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Re-education for living through experience

The aim of this paper is to conceptualize:

- (1) The mental hospital as a social-vocational "community."
- (2) The role of "work" in patient treatment and recovery.
- (3) The co-operative efforts of New York State's Department of Mental Hygiene and Division of Vocational Rehabilitation and plan of relationship.
- (4) The supplementary special programs of the Division of Vocational Rehabilitation.

THE HOSPITAL AS A "COMMUNITY"

The open door policy in state mental hospitals symbolizes the emerging philosophy of interdependent relationship between in-

stitution and its community, suggesting that the community and its institutions are on one continuum of patient care, with each contributing the service it can provide most effectively at the proper time. The role of the institution may be viewed as a function of the range of available community services.

Thus, the more comprehensive the services of the community's agencies, the less the need for institutionalization. The converse would also be true—the fewer the community services, the greater the dependence on institutionalization as a form of treatment. Since the reality of the situation is such that the preventive aspects of community service are still very limited, institutionalization does take place. The role of the hospital in relation to patient treatment and recovery merits our closer examination.

It is postulated that the hospital by its very structure is a "community," and that service and treatment of patients reflect the

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interdependent relationship of a citizen to his community and the mutual responsibilities inherent in such relationship.

A hospital represents most of the aspects of community living. The institution is an entity organized to plan for the feeding, housekeeping, entertainment, instruction, safety, protection, and medical and ancillary care of its "citizens" or patients. It often has newspapers and patient-government structures. Organized or not, there also exists a lively web of interpersonal relationships between patients and patients, patients and staff, and patients and the life of the hospital "community."

Only *one* of the purposes of the institution is to provide custodial care and medical treatment. The long view, however, aims to restore the whole individual so that on release he can adjust to community living. The patient therefore needs treatment through exposure to experiences he will have to face and adjust to when released. To provide him with less is to make him ill-prepared for release. The institution is perforce a dynamic community rather than a period of isolation or pause between admission and release.

The occupational therapy departments and the hospital industries, including the service, maintenance and housekeeping areas, etc., are excellent for the development of work programs that can present graded challenges geared to patient needs. Perhaps we need to re-emphasize that hospital facilities, industries, and personnel exist for service to inpatients rather than services to maintain them in the hospital. With limited facilities and mounting costs, we cannot afford the failure to make full use of a standing plant and staff, as a comprehensive treatment center for social-vocational rehabilitation.

The whole hospital, its plant, facility and staff are members of the rehabilitation

team and should subscribe to and practice a common philosophy; namely, that their respective services, lay and professional, are part of the treatment process to help patients recover and return to the community.

It is the hospital administrator who sets this philosophy and provides the realistic framework within which his staff will function. The hospital administrator, aware of the skills and limits of his staff, co-ordinates them for a comprehensive approach.

THE "WORKER ROLE" OF THE INPATIENT IN THE TREATMENT PROCESS

Mental illness may be viewed as a developmental reaction to social-vocational situations. Inferentially, treatment for recovery should be applied through the medium of a social-vocational setting.

Nowhere in our society is a person encouraged to live without contributing purposeful effort. Even the least competent individual, admitted for the first time to an institution, has within him some of the culture values and adjustment techniques that enabled him to live in society prior to admission. These attitudes and resources may have failed him at the moment but they are there and their capacity for use is temporarily submerged under the greater pressure of the current situation. Should institutionalization change that deeply ingrained and accepted community relationship which the patient brings with him?

Is there such a point in a patient's condition that describes him as psychiatrically ready for work and interaction? Experience suggests that such a static point does not exist. Rather, the patient's condition represents various concurrent levels of relatedness ranging from the normal to withdrawal. Perhaps the patient's ability to work and interact is more a function of our professional capacity to evaluate his present

abilities and structure a situation with him within which he might relate as a "working" and contributing member of the institutional community. Even the patient confined to his bed demonstrates his approach to his adjustment by his willingness to do for himself with professional help and encouragement.

Activities should be goal-oriented and meaningful and afford the patient a *challenge*, an *opportunity* and a *duty* to contribute to his present community—the hospital. If such activity is realistically tied in with his ultimate vocational objective on release, patient motivation to contribute is greatly strengthened. However, this *coincidence* is certainly not an essential.

The personal-social adjustment development is the most important value that can accrue from the work the patient does in the hospital. Therefore, the specific task itself becomes secondary as long as it continues to *challenge* the patient. Follow-up on hospital job assignment and adjustment therein is, therefore, a cornerstone in the process.

From a treatment point of view, the therapeutic services (including rehabilitation counseling) need an objective testing ground to gauge their effectiveness. The social data, observations and interpretations of the interaction of the patient as a "worker" in the institutional community provides the laboratory for the evaluation of treatment plans.

Within the concepts described above, the Division of Vocational Rehabilitation, New York State Education Department and the mental hospitals of the New York State Department of Mental Hygiene are co-operatively providing vocational rehabilitation services to patients in the hospitals. The program emphasizes the use of the hospital's plant and facilities, the community facilities and special supplementary training

programs supervised and *brought into* the hospital by DVR. This constitutes the Liaison Counselor Program detailed below, in which a DVR counselor, on a part-time basis, regularly visits the state hospitals to provide vocational guidance and service to referred patients *while they are in the hospital*.

Purpose of the DVR Liaison Counselor Program

1. Through counseling and guidance to assist selected eligible *inpatients* to develop vocational adjustment and skills through expanded use of hospital facilities such as the occupational therapy center activities, hospital industries and workshops.
2. With medical approval, to develop ways of using the community's adjustment and training facilities as an extension of hospital services to hospitalized patients.
3. To bring community vocational training programs *into the hospital* for use by selected patients *accepted* as DVR clients.
4. To assist the counselor to become a member of the hospital team through mutual education and recognition of the interdependence of helping disciplines in meeting patient's needs.

Assumption in Program Development

1. The hospital is a *community* and a *facility* with many essential aspects of a comprehensive vocational rehabilitation setting.
2. Just as the past social-vocational situation may have contributed to emotional breakdown, so the development of adjustment and recovery should be operative through the medium of social-vocational activities.

3. The inpatient period is an opportunity to develop, and test, work capacity of the patient and minimize loss of skill.
4. The hospital patient, when motivated, desires to work and contribute to his hospital society.
5. *With medical approval*, the community's facilities may be used as an adjunct to hospital service for selected patients.
6. The *inhospital* period provides the DVR counselor and the hospital staff with a laboratory in which to test their effectiveness, and an opportunity to modify or change planning based on the reality of the client's reaction to experience.

Role and Function of the DVR Liaison Counselor

The liaison counselor confines his efforts to the vocational area of his client's total problem. If the client is not ready for such a focus, he is not ready for DVR services. If such is the case, the resolution of the client's "problem" will then lie within the competence of a hospital discipline which may assist the patient and ultimately refer him to the liaison counselor.

As part of serving "under-care" clients and developing channels of communication and referrals, the liaison counselor performs an educative function in the hospital with respect to the value of vocational rehabilitation as a significant contribution to the total adjustment of the psychiatric patient. He joins a staff conference to discuss specific cases under his care and new referrals. He assists the hospital in considering and utilizing the *inhospital* facilities and industries for vestibule training, whose value would include and extend beyond that of the traditional occupational therapy programs.

Under adequate hospital supervision and reporting, such facilities may provide the equivalent of prevocational evaluation, exploration and work tryouts in an atmosphere for developing appropriate attitudes and work habits. Even job training in a specific skill may also be developed through use of hospital industries and facilities. The DVR liaison counselor may also provide information on the availability and use of training and placement facilities in the community, community employment standards and (in consultation with the New York State Employment Service) current labor market conditions and industrial demands.

Concepts of "Work"

It is generally agreed that "work" is a most important tie to reality and a cornerstone in the social adjustment of an individual. By "work" is meant not only the actual task performed but the social interrelationship that is basic to all human activities. This applies to all work whether it is located in a hospital, industry or the home.

The term "work" may have different meanings in a hospital setting. To the patient it may mean self-awareness and recognition by the institution of his growing recovery. Hospital disciplines may view "work" with less concern about specific work skills and more with the patient's readiness for social interaction and challenge.

The State Employment Service requires social readiness and vocational skill for job referral of its applicants desiring job placement. If the applicant lacks in either of these two criteria, job placement is not attempted.

The liaison counselor, however, is concerned with the vocational problems in the context of the whole personality as it reflects present skill and capacity for inter-

relationships and *potential* for the development of social-vocational skills that will meet the demands of the employing community. The liaison counselor's approach recognizes the patient's potential and emphasizes the use of *vocational development techniques* to provide avenues for strengthening the social-vocational skills through counseling and work activities.

Criteria for Referral by the Hospital to the DVR Liaison Counselor

Although some patients may have multiple disabilities which should be considered in planning, the major disablement is psychiatric and reflects itself as a problem in interpersonal relationship and the motivation and ability to be constructive through a work activity. A patient may be considered for referral if:

1. The psychiatrist considers the patient in need of and ready for vocational counseling *and* anticipates that within a three-month period such a patient *with* vocational counseling should be able to enter a vocational activity (at some level) within the hospital or community setting.
2. The patient is currently involved or may become promptly involved in a vocational activity in the hospital or in the community.

These criteria establish the *mutual responsibility* of the liaison counselor and the hospital staff to make use of *vocational counseling* and a *planned inhospital or community work program* to motivate and develop the patient's vocational effectiveness. The "readiness" restrictions deliberately aim to reserve the limited time of the liaison counselor for those patients who can be helped to identify with work and the "worker role."

The Hospital as a Source of Information on the Referred Patient

The record and current psychiatric report describe the disability and limitations imposed, past work history and problems therein, hospital duties and/or jobs, supervision, incentives, status needs and any known physical handicaps. Specific data from the physical, occupational, recreational, social and other therapy modalities further delineate the client as a dynamic individual in the social milieu of the hospital.

The DVR Liaison Counselor's Appraisal of the Referred Patient

The counseling interviews and the assessment of hospital data are the most important initial evaluation media. Counseling establishes rapport and evaluates client feeling and reactions to current hospital or community work, past employment, co-workers, job continuity problems, pressures, competition and status needs. Through counseling we become aware of the client's articulated problems and the unvoiced implications that describe the attitudes, fears, hopes and wishes that are the fabric of his social-vocational adjustment.

DVR Eligibility Considerations for Inhospital Applicants

1. The medical and psychiatric reports on referred cases establish the existence of the *disability and limitations imposed thereby*.
2. Vocational handicap is evaluated by the DVR liaison counselor through the past social-vocational history, the in-hospital social and vocational adjustment and the anticipated vocational conditions and problems on release. The interpersonal problems in work and/or loss of a work skill or need for

a new skill raise the following questions, among others:

- a. Within the framework of emotional recovery, will the patient's present occupation be suitable on release?
 - b. Will the patient require a special work environment to accomodate his emotional condition even though his occupation be suitable?
 - c. Have former skills deteriorated or become obsolete in the present labor market so that the patient will require training or retraining?
 - d. Does the patient with suitable and marketable skills need special counseling and placement services beyond that normally offered by the New York State Employment Service?
3. *Susceptibility* is evaluated through the ability of the client to focus on a vocational role or objective. This may be judged through the patient's active participation in a vocational program in the hospital or the community, or his ability, with vocational counseling, to become so involved. Lack of involvement or predictive ability to participate in a hospital or community work program within three months may provide additional insight into the client's vocational limitations.

Receipt of Referrals and Case Process

Patients are referred by the psychiatrist's use and completion of the brief psychiatric report form, and they are sent to the hospital staff member designated as liaison to the DVR counselor or directly, if so arranged.

Appointments for the patient are scheduled and the patient's hospital chart made available to the DVR counselor on the day of the interview.

It is suggested that, insofar as possible, each regular visit to the hospital be planned in advance for the most effective use of DVR and hospital staff time. New interviews should be allotted approximately one hour and re-interviews, one-half hour. Similarly, advance planning should be considered for discussion of the client with hospital staff and visits to client's work area for direct observation. Only through such planning of time can the counselor accomplish his educative role and the counseling and vocational program development with his client as well as accept new applicants.

The DVR counselor reviews the hospital data and interviews the patient to determine if the eligibility requirements are met. If the patient is not deemed eligible, a written statement by the counselor, indicating reasons, is submitted to the referring psychiatrist through established channels and a copy retained for DVR files. If the client is eligible, a specific plan of counseling and specific work activity in the hospital or community will be formulated as soon as practicable. The work activity in which the patient is involved at the time of referral may be considered satisfactory and, if so, will be included as part of the plan of services on the R-5 (Rehabilitation Plan) after the acceptance of the case. A written statement of the decision and initial plan is presented to the appropriate hospital staff member with enough copies to meet hospital administrative needs.

It is suggested that in most instances the initial conference with hospital staff on a newly referred case be deferred until the counselor has reviewed the hospital chart and data and interviewed and counseled the client. Such consultation with hospital staff may then be more pointed, meaningful and action-oriented. With rejected cases this technique also conserves the time of all concerned and provides the counselor with

an opportunity to clarify for the hospital staff the DVR concept of vocational handicap and susceptibility.

There will be some referred cases in which the decision as to eligibility may *not* be clarified in the initial contact. To conserve counseling time, it is suggested that a decision be made in a maximum of three interviews, since re-referral of rejected cases at a later stage is always possible.

It is emphasized that (with few exceptions) a condition for service by DVR will be early involvement of the patient in a vocational activity in or out of the hospital, suggested or approved by the counselor and hospital staff, and included as part of the vocational plan.

The hospital provides the general medical examination as a special service to DVR clients. To conserve the time and effort of the hospital staff, the liaison counselor should request the hospital to provide the general medical examination *only* for cases to be statistically accepted.

While the client continues to remain a patient in the hospital, his case may be processed into the appropriate status to reflect the service being rendered; e.g. diagnostic evaluation, personal adjustment training, training, etc.

Where necessary, an inhospital case may continue to be counseled and remain in referred status for a maximum of three months.

Personal adjustment training through the use of hospital facilities may extend to six months. Extension of such adjustment training programs through use of a community facility may be necessary and should not exceed six months. Specific vocational training may be provided in the hospital or the community. Direct job placement may be considered, if so indicated, even if the client continues to use the hospital for

domiciliary and medical care. Extensions of the time limits in this section, stating reasons therefore, may be approved by the senior counselor, who will initial the entry.

The counselor's evaluation of his client's potential and needs, coupled with the ability of the client to apply himself vocationally, is a most effective test of counseling and client movement. The district psychiatric consultant would be most helpful in interpreting observations and reactions noted, and in assisting the counselor in planning with the case from a medical and agency consultant's point of view.

Special DVR-Sponsored Inhospital Training Programs

To highlight DVR services in general, to enable the hospital staff to focus on specific DVR activities from which to generalize and to meet specific needs, it was found useful to develop group tutorial programs in such special trades as clerical and commercial, needle trades, homemaking, typewriter repair, radio and television repair and maintenance, machine shop practice, etc. These programs are specifically tailored to develop the client's knowledge and skills as needed in his community adjustment. Private schools and individual teachers and those experienced in adult education are used to develop adjustment and trade training programs under DVR sponsorship and supervision.

Where a community industry provides the "work" to the hospital, the hospital administration designates a representative of the hospital as the contractor. Payment to the patient-worker is made on a piece rate or on an hourly basis, subject to legal requirements.

The liaison counselor assists in procuring the co-operation of manufacturers to provide work to the hospital but *may not act*

as contractor. All financial transactions and payments are made *directly* to the designated hospital representative.

The occupational therapy departments support the DVR special class programs by developing parallel prevocational and pre-industrial classes which serve to screen and develop patients for the more formal and industry-oriented DVR classes.

These special programs reflect the skill needs of the patients, the hospital location, and local employment opportunities. They are an integral *part* of the *over-all* vocational rehabilitation program operated and sponsored by DVR in the hospitals.

At Kings Park, Pilgrim and Central Islip State Hospitals in Long Island, New York, more or less isolated from urban facilities, DVR sponsored a private school to provide equipment and instruction in commercial subjects to inpatients preparing for work in the clerical field. The hospitals provided very adequate quarters and special patient schedules.

At Manhattan, Brooklyn and Creedmoor State Hospitals, based in New York City, DVR sponsored a similar program and, in addition, arranged, with hospital approval, for selected patients to leave the hospital daily for vocational training in the community's facilities. Such patients continue to use the hospital for medical and domiciliary care until released and employed in their home area. At Rockland State Hospital, DVR sponsored a special program of instruction in radio repair and maintenance, which is applicable to the growing field of electronics and instruments assembly. This program utilizes hospital staff as instructors during their off-duty evening hours. At Buffalo State Hospital DVR sponsored a machine shop training program needed in that area.

At Middletown State Hospital emphasis

on the more regressed patients under intensive treatment resulted in the development of clerical and needle trades training, using community persons with teaching backgrounds. In the needle trades, local manufacturers under DVR and hospital supervision are providing "real" piece work at standard rates to patients in the hospital, and patients are responding as workers. Many now hold union cards and jobs in the local factories while they continue to reside in the hospital.

Transportation Problems

Problems of transportation to community vocational training facilities may often be resolved through the use of the hospital or community volunteer services or the hospital motor pool. Where necessary, cost of transportation for the training of patients in the community may be met by DVR in accordance with current regulations.

Posthospital Vocational Planning

In many instances, it may be presumed that at the time of release, the client may need further developmental training, skill training or placement services from DVR. It is important to emphasize that the early phase of transition from the hospital to the community should be supported by counseling and, if advisable, specific vocational training. Delay may cause regression. Preparation of the client for each service he is to receive is essential in order to allay his fears, develop understanding, acceptance and co-operation.

Strengthening positive attitudes and habits requires practice. Adjustment programs, including job training, provide the media for such practices, which are so essential to eventual employment. However, it is the individualized counseling that is the mainstay of the client throughout the service

and in the period of transition. If at all feasible, the DVR liaison counselor should continue to serve the client until he is rehabilitated or his case closed by the DVR office.

Aftercare Clinic Relationship

The district supervisor, in relating to the aftercare clinics in his district, where possible, assigns the DVR liaison counselor to the aftercare clinic of his hospital.

The released patient usually receives follow-up services in the aftercare clinic associated with the state hospital or, in New York City, his borough of residence. The DVR liaison counselor or other designated DVR counselor establishes relationships with the personnel of the clinic for receipt of referrals and ongoing service to "undercare" cases. The nature and progress of the services (e.g., psychotherapy) provided to his client is incorporated in the over-all vocational plan.

Frequently, the liaison counselor receives requests from other DVR counselors to obtain case summaries or other information on "undercare" cases released or discharged from the state mental hospital. Because of the limited time available to the liaison counselor, it is suggested that in general situations such requests be addressed directly to the hospital or aftercare clinic for reply.

It is essential to recognize that the released patient (the DVR client) is the continuing responsibility of the aftercare clinic of the Department of Mental Hygiene. Mutual planning is essential until the patient-client is officially discharged or his case closed.

Case Recording

Essential information is recorded concisely, covering all contacts with or in behalf of the client and briefly conveying the

basis for decision and action. Emphasis is placed on detailing the client's relationship problems and experience, in addition to the normal data of past employment and social history.

The case record reflects the agency's efforts and experience with the vocational rehabilitation program and is an effective tool for further evaluation, planning, supervision, research and policy formulation.

CONCLUSION

The involvement of hospital staff, local teachers, employers and community agencies demonstrates to the community that the emotionally recovered can learn and earn and take their place in society. Equally important is the change in the self-concept of the patient and his relationship to significant peers; that he is not alone in his effort; that he is considered capable of working and contributing; that he can rise to the challenge and win.

SUMMARY

The vocational rehabilitation of psychiatric patients is an organized co-operative effort between the hospital staff and DVR liaison counselor.

The hospital recognizes that

1. The DVR liaison counselor depends upon the hospital staff for casefinding. In some hospitals, the hospital director designates a member of his staff as co-ordinator to establish and maintain communication and referral channels.
2. Since the hospital staff member prepares the patient for referral for vocational rehabilitation, it is advisable that staff be aware of role and scope of DVR services. In this respect the orientation conference at the inception of new programs is helpful, and participation by the

DVR counselor at selected case staffings and other hospital conferences enhances mutual education and co-operation.

3. Certain information for counseling services is essential; i.e., a current medical and psychiatric report. Psychological reports and other special consultation are available.
4. The value and use of hospital industries for patient vocational and psychiatric rehabilitation is desirable, where possible. In addition and within the concept of the "open" hospital, the community's vocational resources may be considered as an extension of the hospital work program. Past experience indicates that transportation problems relative to use of community vocational resources are rarely insurmountable and may be met through a variety of resources.
5. The DVR liaison counselor informs the hospital staff of major movements in a client's rehabilitation program. Since this information is useful to treatment personnel, it is of value for entry in the patient's chart. Similarly, arrangements to advise the DVR liaison counselor of significant changes in the referred patient's psychiatric or medical status; i.e., a relapse and release plan, is necessary. Thus, patient release or transfer to an aftercare clinic does not involve a break in the continuity of relationship with the DVR program.
6. Co-operative programming is an ongoing learning experience for both departments and periodic administrative meetings with the local DVR

office seem to clarify problems and needs.

The DVR liaison counselor:

1. Receives and screens referrals of selected inpatients for service.
2. Evaluates client's vocational potential and plans for program implementation through hospital chart information and counseling.
3. Obtains current general medical examination and psychiatric reports on *eligible* cases.
4. Consults with professional hospital staff for mutual case-planning.
5. Advises the designated hospital staff member, in writing, of the rehabilitation plan and major movements in the case.
6. Recommends the use of inhospital facilities, as available, for the vocational development of specific clients or, if suitable, incorporates the current work activity of the client into the vocational plan.
7. Counsels the inhospital client on a regular basis.
8. Uses community facilities for inhospital clients' vocational development, if medically approved.
9. Develops "special" work programs in the hospital for clients served, which reflect employment opportunities in the community or home area of the client.
10. Addresses hospital staff periodically to orient them to the DVR program.
11. Maintains contact with the client on release from the hospital and co-operates with the appropriate aftercare clinic responsible for the client until DVR services are completed.

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Employment after psychiatric hospitalization: An orientation for Texas employment personnel

One of the primary sources of employment for psychiatric patients following discharge from Veterans Administration Hospitals throughout Texas is the Texas Employment Commission (TEC).

To maintain a smooth and orderly transition from hospital to employment and to capitalize upon what hospitalization has accomplished, TEC personnel who evaluate and place these veterans must understand

the rehabilitation programs from which the veterans have just been discharged. The veteran's visit to the TEC is frequently the first *posthospital* phase of a rehabilitation program that had been under way *during* hospitalization.

To create a closer working relationship and to increase communication and mutual understanding, arrangements were made with the Houston Office of the TEC for a hospital orientation program for TEC placement interviewers and counselors. A total of 38 TEC personnel attended the program which was held on two separate occasions three weeks apart, the second session being a repetition of the first. The group was divided, each half attending a different session.

It was hoped that at least three major objectives could be achieved in these meetings. The first goal was to consider the fact that interviewers were particularly interested in

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learning something about psychiatric hospitalization and its implications for seeking and maintaining employment.

Secondly, the interviewers and counselors were interested in familiarizing themselves with the psychiatric programs of the VA Hospital in order to provide the maximum service for discharged veterans seeking employment. To accomplish these two objectives, the first phase of the orientation program consisted of a panel discussion led by members of the Psychiatry and Psychology Services.

The third goal was to involve the interviewers and counselors in a lifelike experimental situation with patients. The purpose of this experimental situation was three-fold: (1) to give interviewers and patients first-hand experience with some of the problems involved in job-seeking for psychiatric patients; (2) to compare two ways in which an ex-patient might describe his hospitalization in order to evoke a more positive reaction from a prospective employer; and (3) to allow interviewers and patients to share insights gained from the role-playing interviews.

To achieve these objectives, the visitors participated in a role-playing exercise with the patients from a human relations training laboratory at the Houston VA Hospital.¹ The exercise involved a job application interview in which the interviewer would play his "natural" role and the patient (hereafter referred to as a participant) would play the role of the job applicant.

ROLE TRAINING FOR PARTICIPANTS

Participants received about two hours' practice in role-playing and discussion and were given an additional hour to fill out standard employment interview forms used by the TEC.

At the start, the training descriptions of the two types of roles were placed on a flip

chart in view of all participants in general session. The *nerves* role (N) required description of the reasons for hospitalization by the use of such terms as nervousness, nervous condition, nervous breakdown, having been emotionally disturbed or mentally ill. The participant was to describe his treatment in terms of therapy, tranquilizers, and medications, using such "hospital oriented words" as doctor, psychiatrist or ward, and to say that his nerves had been cured.

By comparison, the participant in the *problems* role (P) was to describe his problems in terms of difficulties in his relationships with other people. Each participant was free to formulate these problems of social relations in a description which best fitted him; e.g., shyness, loneliness, fear of accepting responsibilities, difficulty in getting along with bosses, friends and family, or characteristic antagonism toward others. The participant was to explain his hospitalization in terms of learning to solve these problems of social relations.

ROLE ORIENTATION FOR TEC INTERVIEWERS

The employment placement interviewers were told that each would have a 20-minute employment interview with a participant. For these interviews the participants had completed TEC application forms to which a description of the participant's hospitalization was attached.

The description on one-half of the forms portrayed a problem-centered point of view. This description read: "The applicant was having problems in his everyday interper-

¹ The patients taking part in the workshop were participants in the Patients' Training Laboratory, an experimental program designed to train psychiatric patients in problem-solving and interpersonal skills and to increase their social awareness. The program is four weeks long and is held on an open psychiatric ward.

sonal relationships. He attempted, unsuccessfully, to handle these problems by himself. As a result of these experiences, he felt he needed help in solving these problems and entered the VA Hospital." The nervous condition approach, illustrated on the other forms, read: "The applicant entered the VA Hospital because he was having trouble with his nerves. He wanted treatment for his nervous condition."

The interviewers were told to look over the application form and the description attached to it and to rate the degree of difficulty that would be encountered in placing the applicant on a job (Fig. 1, Scale 1). The interviewers were also told that the participant would further explain his hospitalization during the interview, after which they were to rate again the participant's potential for job placement (Fig. 1, Scale 2).

PROCEDURE

During the first workshop half the participants played the "Problems" role and the other half the "Nerves" role. The description attached to the participant's application card coincided with the particular role he was playing in the interview. The same participants reversed their roles in the second workshop with a different group of interviewers, playing the role alternative to the one they had played previously. The descriptions on their application cards were also reversed to conform to the role they were playing in the current workshop. Thus, each participant and his application card was seen by two interviewers under different role conditions.

Following a separate briefing session for both the job applicants and the Texas Employment personnel, the interviewers came

FIGURE 1

Scale 1. Applicant's Name

Based on the Application Card, which includes the attached description of reasons for hospitalization, rate how difficult you think it will be to place the applicant on the job.

1	2	3	4	5	6	7	8	9
An impossible job placement	A very difficult job placement	A difficult job placement	A little more difficult than average job placement	An average job placement	A little easier than average job placement	An easy job placement	A very easy job placement	Job placement a certainty

WHY?

Scale 2.

Based on your interview with the applicant and his description of the reasons for, and nature of, his hospitalization, how difficult do you think it will be to place him on the job?

1	2	3	4	5	6	7	8	9
An impossible job placement	A very difficult job placement	A difficult job placement	A little more difficult than average job placement	An average job placement	A little easier than average job placement	An easy job placement	A very easy job placement	Job placement a certainty

WHY?

Employment after hospitalization

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into the ward and were paired with the applicants for the employment interview. Immediately after the interview, the interviewers completed their rating forms and returned to the assembly room with the participants for a general discussion about problems of seeking employment and to learn the results of the role-playing experiment.

EXCERPTS FROM THE GENERAL DISCUSSION SESSION FOLLOWING ROLE-PLAYING JOB INTERVIEWERS WITH TEC INTERVIEWERS AND PARTICIPANTS^{*}

Dr. Rothaus: "The topic for this open discussion will be 'Problems of locating jobs after hospitalization.' Since they are involved from day to day in the business of placing people in jobs, the TEC people have a lot to offer us by way of information, insight, and perspective. We feel, at the same time, that it would be a good opportunity for them to increase their sensitivity to some of the problems that confront a person leaving the hospital as we see them. So we see that we have an excellent chance for an exchange of sensitivity and perspective."

Participant: "Well, I'd like to know how these people feel about a man who has been in a mental hospital, so to speak, and whether it has any bearing on where his card goes in the file, whether it goes to the back or to the front."

Dr. Rothaus: "Would any of you care to answer that?"

TEC: "It goes in the front."

Participant: "Are there ever any exceptions to this rule?"

TEC: "Of course, every job has to be filled according to the requirements of the job,

but I believe you asked personally how we feel?"

Participant: "Yes, Ma'am."

TEC: "I feel that any of us could be here, and that you're here and being treated and when you come out, you're ready to do whatever you can. The law requires us to give a veteran preference; that's why your card is placed in front of our other cards."

Participant: "What if the law didn't provide for that; would it make any difference?" (Laughter)

TEC: "I don't think so."

TEC: "They say that one out of every ten will have to have treatment for nerves sometime during their life; it's such an ordinary thing to us because we have people like that all the time; we really don't think a lot about it."

Participant: "It would seem to me that a person coming out of the psychiatric ward or mental institution would be very definitely running into problems when they go out to find a job. I'd like to have some more comment on that."

TEC: "I think it might be helpful if I talk about the person I've just role-played with in regard to how we consider him as far as placement is concerned. He hasn't had any long, serious hospitalization or any physical trouble. His main trouble is that he is now unemployed. He left his job to come to the hospital and he'll have to go out and more

^{*} Because of mechanical difficulties, the discussion session in the first workshop was not transcribed. The excerpts from the general session transcribed in the present paper took place during the second workshop and were edited for clarity. There were 10 interviewers and about 50 patients from several wards present. The previous workshop attendance was approximately the same. Only those patients from the training laboratory were involved in the role-playing exercise.

or less seek another job. 'What is his chance?' is that what you're asking? How important is the fact that he's been hospitalized?

"I marked the application card that he needed help to evaluate his skill and how it could be related to other jobs. He is not likely to go back to the particular job he had before, but there are many similar jobs he can go to. Then you've got to think when you tell the employer about this man's skills and ability: 'What is he going to say about his hospitalization?' That's what I asked the man. And he said, 'Well, I feel like I, well, of course, may come back, but so may you,' which is certainly true.

"He said that the doctor told him he could tell this to his employer and it would break down the opposition to this mental situation. There are some employers that might say: 'That man is well-adjusted and doesn't have an extra psychological hazard because he's met his problem, understands it and accepts it; he won't have much trouble.' That worked for that person fairly well."

Participant: "From the standpoint of your experience talking to employers, what would be the disadvantage a person in the hospital would have as compared to a regular person who hasn't had a hospital background? In other words, would the employer react differently to a person in the hospital?"

TEC: "Well, speaking in general, I would ask the particular employer because employers aren't going to agree. Each one is different; one may have to be sold harder than the other. That's true of any person, any difficulty. An employer may not want someone who jumps from job to job or he may have another man qualified to do the same thing. You've got to get the employer to give the man a chance."

Participant: "In other words, you haven't noticed any general trends; this is all more or less individual?"

TEC: "Yes, there are some general trends, like an employer may say he won't accept anyone who's had any handicap at any time. If he's running the business we have to go along, but we can at least attempt to break the bias down if a person is well-qualified in his field. Anyone can have a handicap at any time."

Participant: "What do you feel is the percentage of breaking down a bias when a man's been in a mental institution?"

TEC: "Well, a great deal depends on why."

Participant: "Does this happen a great deal? I mean, do they refuse employment to a person coming out of a mental institution?"

TEC: "My experience has been that they will, on a small scale, refuse. A lot depends upon how a man does the job. When I talk to an employer I say, 'Try this man, see what he does, see whether you want him or not.' I put it just that way. A lot depends on what you can do, and what the man will do. I have known some employers who will absolutely not talk to them, but there have been very few in the groups that I have talked to."

Participant: "I was told that Civil Service could not, according to the law, hire anyone with 50 per cent disability. I was just wondering if . . ."

TEC: "No, that's not true. When you apply for Civil Service, you're rated either by the Civil Service examination or on the basis of your experience and education for the job. When the time comes for an appointment, you're given a physical examination. The doctor has the description of the job you're going to do and he examines you in the

light of your ability to do that job. If the job required heavy physical labor and you had a bad back, he wouldn't pass you for that job because you aren't physically able to handle it. But you're not rated on your condition before the time of appointment."

Participant: "Well, from your experience as an expert job interviewer and from your past experience in placing people in jobs, do you think it's best to admit or deny the fact that you have received psychiatric treatment in a hospital? I'll put that on a little different basis. Now, say that I have a physical defect and also had been in a mental institution. Now suppose that I had refrained from telling you that I had been in the mental hospital, but told you I was hospitalized for some physical ailment and it came to light later. How would that affect the man's file from then on? Where would you all place the card?"

Dr. Rothaus: "The question is apparently in general terms. What do you think of the wisdom of trying to conceal hospitalization?"

TEC: "Never, never."

TEC: "It's best to admit it, but don't elaborate on it. I mean, let them know that something went wrong and what went wrong, but that you've taken care of it and now you're ready to go back to work. Let it go at that."

TEC: "I think that each individual case has to be considered there. Quite often the counselor or interviewer at the employment office can pave the way for you if he knows the truth. If we don't know the truth you'll be sent on job after job after job and maybe never get it. We need to know everything about you, but it doesn't necessarily all have to go on the card. If it does go on the card, we can place it there

in such a way that it will be an asset instead of a handicap."

Dr. Rothaus: "This is a point at which I'd like to step in now, because I feel we can now describe what took place in the interviews. You were saying that if you know all the facts it might be possible for you to present a description of the man that would give him an advantage. In other words, the same facts can be described from many different points of view, and some descriptions may give the man an advantage over others. We here have been interested in the same thing, too, and have been actively experimenting with different ways of describing the reasons why patients came into the hospital. I'd like to turn to one of the participants now; would any participant care to distinguish between the two roles that have been played over the past two weeks?"

Participant: "Half of us played the role of a nervous disorder; we were hospitalized strictly for nerves, poor concentration, and under tension; we needed medication, sedatives and tranquilizers, etc. The other half played the role of trouble-whipped people who had problems with humanity itself; people who were disgusted with themselves, were shy and lonely, or couldn't get along with their fellow man whether he was wife, boss, or anyone."

Dr. Rothaus: "That's right. It's very possible for him to use either kind of description about why he came into the hospital; nerves or difficulties in his relationships with other people. Both ways make very good sense. Now from your rating forms, I'd like to summarize the results of your reactions to these two types of descriptions (at this point the following tabular presentation was demonstrated; Figure 2).³

³ Analysis of variance revealed a significant gain from the application card description to the interview. Although there was no difference between

"First of all, there was the application card we rated, with the written descriptions of the reasons for coming to the hospital. If you remember, the rating scale represents how easy it would be to place the man on the job (See Fig. 1). Half the forms last week described the man in terms of having had problems in getting along with people. The average ratings received by these forms was 4.1. This is the *problems* approach. The person that was described on the card also went into an interview with one of you where he continued to describe his problems with people and trying to solve these problems.

view and continued to talk about their problems in terms of nerves, they made little if any headway, whereas if they continued to talk about their personal problems, they did make some progress.

"Now, the second set of results that you all gave today were slightly different. This week the initial reaction of interviewers to the *problems* approach on cards was 4.2 and in the interviews, 4.5. The trend is essentially the same as last week but not as pronounced. When a guy took the *nerves* approach, the reaction jumped from 3.7 to 4.3.

"I'd like to generalize these findings: in

FIGURE 2

	1st week Problem- centered	Nerves	2nd week Problem- centered	Nerves
Application Card	4.1	5.2	4.2	3.7
Interview	6.2	5.4	4.5	4.3

"After this interview you rated him again. These people jumped from 4.1 on the cards to 6.2 after the interview. Now, by contrast, the cards and interviews that described the hospitalization in terms of *nerves* got ratings of 5.2 and 5.4, respectively. The reaction to the description of nerves was more favorable than the problems on the card, but when the applicants went into the inter-

viewed; regardless of what style of describing yourself you take, whether it's nerves or problems, the interview seems to give you an advantage because there is a certain amount of pickup."

Participant: "Paul, would you say that it is proved by the fact that advertising will sell but the salesman will sell better?"

Dr. Rothaus: "Maybe that's the way to put it, Murray."

Participant: "I have one question, a clarification of some of the questions or generalizations. Number one, in leaving the hospital and going to the TEC, you all feel that we should not refrain from mentioning our hospitalization. Number two, you feel that a person who has received psychiatric treatment should be able, in some way, to

ways of describing hospitalization on the application cards, an interaction occurred which indicated a significantly more favorable response, in the interview, to the problem-centered than to the nerves approach.

While the total N was 38; 19 interviewers participating in each workshop, the experimental results are based upon 32 interviewers rather than 38, because 3 of the original participants were replaced for the second session. A more formal paper describing the experiment and results with other information appears in the *American Psychologist*, 18(1963), 85-89.

verbalize what his situation was when he came into the hospital and when he left. Do you rate that in any way when you're interviewing him?"

TEC: "I believe it would depend upon complexities. We might need more information; some word of his progress here or the fact that he came and has improved. How does the doctor feel he will be if he goes on a job which will have a certain amount of stress? How does the doctor feel about this type of work that he is seeking?"

Participant: "Does that information get passed on to the employer?"

TEC: "Not particularly, and yet I know many an employer who will feel, 'Well, I know exactly what this man can do and how physically or mentally able he is. We'll not push him in something that will put too much of a strain on him.' You'd be surprised how many employers are quite willing, provided they know how much to expect. Then they'll try to keep you in that type of job. Are you going to be willing to accept a little more mediocre job than perhaps you've done in the past? Maybe the job you've done in the past might have been so strenuous that it was probably one of your reasons for coming here.

"If you'll take a job with a little less strain you could be promoted back or even above the type of work you had left before. But you've got to be willing to take a little less of a position than you had in the past. Quite often people are not realistic. They come in saying, 'I was vice-president of this or that and that's what I want.' Well, that isn't where you're going to be put; let's face it."

Participant: "Would they be just as satisfied with a person who had had a nervous breakdown as with anyone else?"

TEC: "The fact that you recognized your problem and did something about it would weigh heavily in your favor. Many employers are more impressed with a stable work history than with the fact that you found it necessary to do something about your nerves."

CHANGES IN PATIENTS' ATTITUDES TOWARD REVEALING HOSPITALIZATION AS A RESULT OF THE TEC WORKSHOPS *

To evaluate one of the effects of the workshops on patients' attitudes toward revealing their hospitalization to the TEC, a rating form was administered at the end of two successive human relations laboratories. The laboratory selection procedures and programs were the same for both samples. Patients in the first laboratory, however, were exposed to the workshops, whereas those in the second laboratory were not. It was hypothesized that the patients exposed to the workshops would be more inclined to reveal and discuss their hospitalization than those patients who were not exposed to the workshops.

The first question on the rating forms revealed that all patients in both laboratories were familiar with the TEC. The second question asked the patient if he would be willing to describe his hospitalization openly to an interviewer from TEC. The patient checked his response to this question on a three-point scale: (1) I would hide the fact that I had been hospitalized; (2) I would not bring up my hospitalization unless he asked me about it; and (3) I would tell him about my hospitalization.

An analysis of the patients' responses sup-

*One interesting result of the workshops occurred during the weeks that followed. Daniel McCall, the vocational placement specialist, received phone calls for job openings from several TEC personnel with whom he had not had previous contact.

ported the above hypothesis at the 4% level of confidence.⁵ That is, those patients who participated in the workshop were more prone to reveal and discuss their hospitalization than were the patients not involved in the workshops. A breakdown by percentages revealed that for those patients who attended the workshop, 25 per cent of them remained skeptical (checked items #1 and #2 of the scale), whereas for those patients who were not exposed to the workshop 50 per cent would not be inclined to reveal their hospitalization.

SUMMARY AND DISCUSSION

Placement interviewers and counselors of the Texas Employment Commission (TEC) took part in two workshops at the Houston VA Hospital to explore problems psychiatric patients have in obtaining work. Interviewers were paired with patients in a human relations training laboratory in simulated job interviews.

Unknown to the interviewers, the patients played instructed roles. In the first workshop one-half explained their hospitalization in terms of "nerves," the other half in terms of "problems;" patients alternated roles with a new group of interviewers in the second workshop. Interviewers rated their impressions of patients from application card descriptions and personal interviews. A general forum followed, which included discussion of the data from the rating scales.

⁵ A Mann-Whitney U test for ranked data, corrected for ties, was utilized for the analysis. Since the prediction was unidirectional, the level of confidence is based on a one-tailed test. There were 20 patients in the first laboratory and 22 in the second.

⁶ Nunally, Jim, "The Institute of Communications Research Study," in Bloomberg, W., ed., *Psychiatry, the Press and the People* (Washington, D.C.: American Psychiatric Association, 1956), 5-12.

The results indicated that it was advantageous to get past the application card into the interview regardless of which role patients played. Once in the interview, however, the interviewer reacted more favorably to those patients playing a "problems" approach than to those patients who continued to use the "nerves" approach.

The preceding presentation illustrates the way a workshop can be used as an experimental situation in which the participants learn from the data which they themselves created. Since the data is the "personal property" of the participants, the results have greater impact upon them. The personal involvement in creating the data of an experiment (in contrast to passive reception of information) makes the experimental workshop a learning situation par excellence.

Because of the face-to-face nature of the experimental workshop the problems of motivation and communication discussed by Nunally⁶ are overcome. Nunally suggests that unless motivation is high on the part of the recipient, information about mental health disseminated through mass media will not bring about changes in attitudes.

Some of the reactions to the workshop and the impact it had on the participants do indicate that positive changes in attitudes occurred for both patients and interviewers. A follow-up questionnaire showed patients more prone to be candid about their hospitalization. They have also expressed more willingness to visit the TEC after hospitalization.

In addition, greater communication between hospital and TEC personnel has occurred as a result of these workshops. A regular scheduled visit to the hospital has been set up once a month for them to participate with patients in group discussions

Employment after hospitalization

HANSON, ROTHBAUS, CLEVELAND, JOHNSON AND MC CALL

about problems of posthospital employment. Plans are now in progress for future workshops of longer duration to include TEC offices from other areas of the state to which hospitalized veterans will return to seek employment. Employment personnel participating in these VA workshops will undoubtedly develop a perspective which will serve them well as they work

with psychiatric patients from all institutions.

ACKNOWLEDGMENT

The authors wish to express their appreciation to Homer Jackson and Sargent Braden, Director and Assistant Director, respectively, of the Houston office of the Texas Employment Commission, for their co-operation in setting up these workshops.

Book Reviews

A TREATISE ON THE MEDICAL JURISPRUDENCE OF INSANITY, BY ISAAC RAY

Edited by Winfred Overholser, M.D.

Cambridge, Mass., *The Belknap Press of Harvard University Press*, 1962, 376 pp.

It is a miracle indeed that this, the pioneer work in the United States on medical jurisprudence, was written by a general practitioner who lived and worked in a tiny village in Maine and had never had extensive psychiatric practice.

Dr. Ray was only 31 when he wrote this book in 1838, but he showed an intimate knowledge of all the best European writing in the field. His work did much more than merely echo European opinions, however. Its fearless, original and dynamic opinions did a great deal to further humane treatment for persons whose mental illness caught them in the snarls of the law.

This edition, the first since the fifth edition of 1871, is attractively presented, with an excellent introduction by the editor, Winfred Overholser, M.D., an authority as pre-eminent in this century as Dr. Ray was in the last.

The over-all impression (on a reviewer who is a lawyer, not a psychiatrist) of this rich and moving treatise and the dramatic and fantastic cases it describes is amazement at how much of modern attitudes and modern approach its author displayed, and yet, suddenly, at the great gulfs which appeared periodically between Dr. Ray's time and ours.

We cannot fairly blame a genius of a century ago for not having answered to our satisfaction all the questions that plague us today. Dr. Ray, with his tenacious belief that all insanity must have a

physical cause, was ahead of his time, yet this theory would raise many eyebrows in 1963, as would his other basic assumption that we know, clearly, the differences between the purely physical and the purely mental.

Even more debatable is Ray's certainty that no person should be punished for acts resulting from mental illness. He never appreciates that this approach, at its logical limit, would turn all criminal law and much civil law into medicine, for law postulates responsibility of ordinary men for their willed acts, without probing very far, in most cases, into what made those men willing to do those acts.

Forensic psychiatry and law are twins, but they are not identical twins. The medical question, and the question society puts through law, are not identical. Law has to treat many deviants as guilty of legal offense, however convincingly the reasons for their deviations may be explained by the doctors. These are troublesome questions of sociology and law. Dr. Ray was wrong in thinking them yes-or-no medical questions. They are an aspect of a mass of problems which are likely to remain unsolved for many years and many decades to come.—BERTRAM F. WILLCOX, *The Cornell Law School, LL.B., Ithaca, N. Y.*

THE MENTAL PATIENT COMES HOME

By Howard E. Freeman and
Ozzie G. Simmons

New York, John Wiley & Sons, Inc., 1963, 309 pp.

The inability of many former mental patients to become successfully reassimilated into the vocational and social life of the

community is investigated in this work. The need for many modifications in both current treatment programs and research planning is cited.

Richard H. Williams, M.D., chief of the Professional Services Branch of the National Institute of Mental Health says: "This study and the perspectives of the authors on posthospital rehabilitation challenge much of the current thinking in the field. In view of the continuity of research maintained in the series of surveys conducted by the Community Health Project, and of the replicative nature of these studies, it seems clear that the findings reported in this book represent a substantial body of knowledge that must be taken into account in the further development of rehabilitation programs."

This study determines factors affecting the ability of patients to remain in the community after hospitalization and investigates their performance after hospitalization. It was part of a long-range research program on the rehabilitation of the ex-patient initiated jointly in 1953 by the Community Health Project at the Harvard School of Public Health and the Professional Services Branch of the National Institute of Mental Health.

The interview method was used to gather data from patients' family members. The posthospital experiences of 649 former mental patients, including living and family arrangements for the immediate years after hospitalization, are described.

The relationships between the stages of rehabilitation of former mental patients and the characteristics of their family and family settings also are discussed.

The authors shared in the Hofheimer Prize of the American Psychiatric Association for 1963 for this work.—HARVEY E.

WOLFE, International Society for Rehabilitation of the Disabled, New York, N. Y.

THE MEASUREMENT OF ABILITIES

By Philip E. Vernon

New York, Philosophical Library, 1961, 276 pp.

This is a revision of what is perhaps the finest elementary book on the measurement of achievement and abilities.

The book has both the many advantages and the relatively few disadvantages of combining within a single integrated context the principles of measurement, the statistical methods involved, the practical problems of devising and marking tests, and the theory of the structure of abilities. It was written originally for teachers in training, and it is probably the outstanding text in this field.

It is of little consequence to American readers that one function of the revision has been to bring the book up-to-date with respect to the business of selection for secondary education, as it was changed by the passing of the 1944 Education Act in Great Britain.

It is of consequence to American readers, however, that Professor Vernon has revised his chapter on the analysis of abilities to take into account the newer findings of the factor analysis of measures of abilities and that he gives what he calls "a more reasonable picture of the relations of innate and acquired abilities." He has also revised the statistical chapters and has reconstructed and brought up-to-date his chapter listing and descriptions of the published mental tests.

Anyone looking for a book which explains quite simply the principles of mental testing and how to apply these principles to

the mundane problems of constructing tests—even achievement tests for courses—will search in vain for a better one. The list of references is adequate to lead one to any source in this field, and the index is well-enough constructed to make the book very useful as a quick reference for specific points.—D. McV. HUNT, PH.D., Department of Psychology, University of Illinois, Urbana, Ill.

COMMUNITY MENTAL HEALTH AND SOCIAL PSYCHIATRY: A REFERENCE GUIDE

Committee of Harvard Medical School and
Psychiatric Service, Massachusetts General
Hospital

*Cambridge, Mass., Harvard University Press, 1962,
161 pp.*

This paperback book presents, in the form of an annotated bibliography, a review of the publications in the field of community mental health and social psychiatry. The period covered is from May, 1954, to January, 1960. The authors include a section on related fields of interest which are not central to mental health but are tangentially relevant.

The book is organized into five main sections: (1) Introductory readings; (2) Community mental health and social psychiatry (substance); (3) Related fields and areas of interest; (4) Supplementary bibliographical and statistical sources; and (5) Information and funding sources for research and training in mental health. Some of these sections are further categorized. The organization into the five categories of material is simple; yet it gives some basic order to the material.

In addition, there are two appendices; one describes the method of compilation, and the other lists the 86 journals reviewed.

The last 58 pages comprise the dictionary index.

This book takes a comprehensive view of this extremely amorphous, burgeoning field of literature. The principal works of substance in the field have been included; there is also considerable detail in the areas of particular interest to the authors. This is the only volume I know of which provides a guide to the literature in this particular field.

There is coverage of all the various aspects of the subject. However, all areas are not given equal time. Some subjects are covered by referral to a previously published bibliographical source; e.g., drug addiction, where one extensive previous bibliography is mentioned.

Such a bibliography stands or falls on its index. Here the index is complete, convenient to use, and relates well to the content. I should think this book would be essential to all mental health libraries, and extremely valuable to individuals in the field.—SAMUEL P. OAST, III, M.D., New York City Community Mental Health Board, New York, N. Y.

MENTAL HEALTH (SCOTLAND) ACT, 1960. COMPULSORY ADMISSION TO HOSPITAL AND GUARDIANSHIP: NOTES ON PARTS I AND IV OF THE ACT

Department of Health for Scotland

Edinburgh, Scotland, Her Majesty's Stationery Office, 1962, 102 pp.

In June, 1962, a new mental code went into effect in Scotland. This paperback on the new code has been issued for the guidance of hospitals and practitioners. In general, the code may be described as a liberal and flexible one, aimed at affording maximum protection to the civil rights of patients. For

the most part, the burden of proof is consistently on the hospital staff to show that the patient cannot be safely released.

In Scotland there is now a Mental Welfare Commission which exercises a protective function over "the mentally disordered" (this includes mental defectives). This commission can even order the discharge of a patient against the will of the hospital. Each hospital has a Board of Management which includes few, if any, physicians. This board also may order a patient's discharge. In fact, the patient's nearest relative may "order" his discharge, although the hospital staff may block this by proving beyond a reasonable doubt that the patient is dangerous. The same restriction applies to board-ordered releases, but not to discharges ordered by the Commission.

During the fourth week after admission, and at regular intervals thereafter, each patient must be examined and the findings relayed to the Mental Welfare Commission. The patient's right to send out letters is zealously protected. Under no circumstances may letters to members of Parliament or to the Commission be censored; and letters defamatory of hospital or staff must be sent on.

The Act also provides for guardianship of patients who need not be detained.

This pamphlet has, of course, little application to procedures on the west side of the Atlantic. However, it is an interesting reflection of the liberal and open attitudes toward mental illness and defect which seem to work so well in Scotland.—HENRY A. DAVIDSON, M.D., Essex County Overbrook Hospital, Cedar Grove, N. J.

Notes and Comments

MENTAL HEALTH WEEK TO BE DEDICATED TO CARRYING FORWARD PRESIDENT JOHN F. KENNEDY'S MENTAL HEALTH PROGRAM

The National Association for Mental Health has announced that Mental Health Week and the 1964 mental health fund-raising campaign "will be related to our responsibility of carrying forward the late President Kennedy's mental health program."

The news of the President's death reached delegates to the 13th Annual Meeting of the Association the third day of the conference, held in Washington, D. C., November 20-23. The NAMH Board of Directors immediately adopted two special resolutions. One concerned itself with an expression of sympathy and bereavement.

It urged that the "National Association for Mental Health rededicate itself and all of its members to work unceasingly for the availability of modern mental health facilities adequate to meet the needs of all communities; to insure sufficient trained personnel and other personnel to make diagnosis and treatment available to all who need it; and to press the research drive for improved therapeutic agents and procedures."

The other resolution concerned itself with the carrying forward of President Kennedy's work, and it urged that "The National Association for Mental Health take all possible steps to enshrine the memory of President John Fitzgerald Kennedy as part of the living and continuing symbol of everything this Association stands for . . ."

The night before his tragic death, President Kennedy had sent a telegram to the NAMH 13th Annual Banquet. In this message the late chief executive said:

"Today it can be truly said that this na-

tion is entering a new era in the treatment of the mentally ill. Two new laws, recently enacted by the Congress, provide significant new means and greatly renewed hope for meeting the problems we face in the field of mental health. Your Association has been instrumental in bringing about increased public understanding of the problem of mental illness and in establishing some effective approaches to its treatment and cure. I am sure your members will continue their efforts to insure that the mentally ill receive compassionate and competent care within their own communities."

In his first message to Congress, President Lyndon B. Johnson called on the nation to help translate into action a number of the late President's "dreams," including his "dream of an all-out attack on mental illness."

COMMUNITY MENTAL HEALTH CENTERS ACT BECOMES LAW

On October 31, just three weeks before his death, President Kennedy signed into law the Mental Retardation Facilities and Community Mental Health Centers Act of 1963.

On October 21, both the House and the Senate passed the bill as finally drafted by a Senate-House Conference Committee. The measure authorizes a \$329 million program on mental health and retardation. It carries no provision for initial staffing of community mental health centers.

The following programs are authorized in the bill:

1. Grants of \$150 million over three years to the states to help build community mental health centers.

2. Grants of \$26 million over four years to aid in construction of mental retardation research centers.

3. Grants of \$32.5 million over four years

for university-associated research and treatment facilities.

4. Grants of \$67.5 million over four years to the states to help construct treatment facilities for the mentally retarded.

5. Grants of \$53 million over three years for programs to train teachers of mentally handicapped children and for research on education of these children.

In the measure originally passed by the Senate last May, by a vote of 72 to 1, there was a provision of \$427 million to assist in the initial staffing of the community mental health centers. This provision was eliminated, by a vote of 15 to 12, by the House Committee considering the measure. The House passed the bill on September 10 with the staffing provision eliminated.

Because of the discrepancy between the Senate and House versions, the bill then went to a Senate-House Conference Committee for reconciliation. Throughout the weeks in which this committee was considering the bill, the Senate conferees were strongly in favor of reinclusion of the staffing provision, while the House conferees opposed it.

\$183 MILLION VOTED FOR 1964 NIMH BUDGET

Congress has voted \$183,288,000 for the fiscal 1964 budget of the National Institute of Mental Health. The record total is \$40 million over the sum voted by Congress for fiscal 1963 and \$58 million over the 1962 figure.

The Senate had voted \$190 million for the Institute for the current fiscal year. This was the same total that was requested by President Kennedy.

The major cut in the President's budget came in a proposed \$12 million item for hospital improvement project. Conferees voted \$6 million for the new item, which

provides funds to set up demonstration projects in the state mental hospitals on the utilization of new treatment methods and procedures.

An additional new item included in this year's budget is a \$3 million provision for inservice training. Another major item is the appropriation, again this year, of \$4.2 million to enable the states to set up long-range plans for comprehensive mental health services.

It is expected that nearly \$7 million of the total NIMH budget will go to the new National Institute of Child Health and Human Development for programs relating to mental retardation and mental illness.

The 1964 NIMH budget includes \$73,906,000 for research; \$66,048,000 for training; \$8,544,000 for fellowships; \$10,950,000 for state control programs; and \$23,850,000 for direct operations.

AWARDS AND GRANTS

Reuben Hill, Ph.D., research professor of sociology and director of the Family Study Center at the University of Minnesota, received the E. W. Burgess Award at the 1963 Annual Meeting of the National Council on Family Relations. The award was presented in recognition of Dr. Hill's "continuous and meritorious contributions to theory and research in the family field."

* * *

Mrs. Sidonie M. Gruenberg, Mrs. Sargent Shriver and Benjamin Spock, M.D., received awards at the 75th anniversary dinner of the Child Study Association of America. Mrs. Gruenberg, director of the child study group for more than a quarter of a century and now a special consultant to the agency, was honored for her pioneer work, which began in 1906, in the fields of child development and parent education.

Mrs. Shriver, a member of the National

Advisory Child Health and Human Development Council of the U. S. Public Health Service, received her award for "championing the cause of mentally retarded children and translating concern for them into action."

Dr. Spock, well-known pediatrician, counselor and author, was cited for "his contributions to countless parents and children as doctor, teacher and friend."

* * *

Robert H. Felix, M.D., director of the National Institute of Mental Health, has received two awards for "outstanding contributions to psychiatry"—the annual Nolan D. C. Lewis Award and the Salmon Medal.

The Nolan D. C. Lewis Award was presented to Dr. Felix by the New Jersey Neuro-Psychiatric Institute. The award was established six years ago by the Board of Managers of the Institute to honor its retiring research director.

The Salmon Medal was presented to Dr. Felix by the New York Academy of Medicine. The award was given in New York City December 5 at the annual Thomas W. Salmon lecture. Although annual lectures have been sponsored by the Salmon Committee on Psychiatry and Mental Hygiene since its founding in 1931, the medals are given infrequently. Only two have been awarded in the past 30 years, the first in 1942 to Adolf Meyer, M.D., outstanding American psychiatrist, and the other in 1945 to Joseph Moore, M.D., one of the discoverers of the spirochete of syphilis in the brain of paretics.

CONFERENCES, MEETINGS SEMINARS

State mental health leaders from 16 Southern states met in Atlanta, Ga., in October, 1963, for a work conference on programs of

care for the mentally ill following their release from state hospitals. Among experimental programs of aftercare discussed during the conference were the foster care program of the mentally ill in Maryland; the public health nursing program in Georgia; the mental health centers in Texas; and the public welfare-nursing home program in North Carolina.

* * *

The American Orthopsychiatric Association will hold its 41st Annual Meeting at the Conrad Hotel in Chicago, Ill., March 18-21, 1964. Primary topics of discussion will be new knowledge in the field of mental health and the factors of social change now affecting the normal growth of human beings and of society.

IN MEMORIAM

Elvin M. Jellinek, Ph.D., a leader in the field of alcoholism research, died in October, 1963, in Palo Alto, Calif. Dr. Jellinek had been visiting professor of psychiatry and a research associate at the Institute for the Study of Human Problems at Stanford University since 1962. He also was a member of the Co-operative Commission on the Study of Alcoholism.

He was director of the Yale University School of Alcohol Studies from 1941-1950. He was one of the first to bring out the fact that alcoholism was a disease and that alcoholics should be treated as sick people. "Alcoholism may be the source of much human misery," he concluded, "fundamentally human misery is the source of alcoholism." He expressed these and similar views in countless articles, books and radio talks.

* * *

Two distinguished officials of the American Psychiatric Association died during

the summer of 1963. APA treasurer Walter Obenauf died July 17 at the age of 56, and APA past president Arthur P. Noyes, M.D., 83, died August 21.

Dr. Obenauf was superintendent of the Pontiac, Mich., State Hospital, a post he had held since 1959. Dr. Noyes was internationally known for his text *Modern Clinical Psychiatry* and for his distinguished career as a hospital administrator.

ARTICLES SCHEDULED FOR PUBLICATION IN FUTURE ISSUES OF MENTAL HYGIENE

"Identity and Ethnocentrism in American Negro College Students" by Robert L. Derbyshire and Eugene B. Brody.

"Differential Teaching Techniques for Emotionally Disturbed Children" by Donald A. Leton.

"Alas! For the Moving Generation . . . An Essay on Residential Movement in the United States" by Ruth B. Caplan.

"Learning Mental Health Consultation, History and Problems" by I. N. Berlin.

"The Homosexual's Image of Himself" by Lt. M. J. Horowitz.

"The High Cost of Nonpsychiatric Care" by Charles E. Goshen.

"Technical Alternations in the Psychotherapy with an Adolescent Cerebral Palsy Patient" by Arnold S. Carson.

"The Child Psychiatrist in a State Industrial School" by Povl W. Toussieng.

"Psychiatric Consultation with Nurses on a Leukemia Service" by Abraham Wodinsky.

"Unique Aspects of University Health Service Psychiatry" by Melvin L. Selzer.

"Methodological Problems in Evaluating Follow-up Services to Psychiatric Patients" by Paul V. Lemkau.

"Influences of Previous Help-Seeking Experiences on Applications for Psychotherapy" by Betty L. Kalis, Edith H. Freeman and M. Robert Harris.

"The Nurse-Patient Relationship in a General Hospital" by John C. Nemiah.

"Resistance to Psychological Care of Hospitalized Children: Observations on Socioprofessional Factors in the Resistance Process" by Arthur Stein.

"A Tale of Moses: Post-Doctoral Interlude" by Arthur L. Rautman.

"Symbiosis of Hospital and Community: Opinions of Residents, Employees and Volunteer Workers" by Charles V. Lair and Allen W. Byrnes.

"Psychiatry Re-enters the Community" by C. H. Hardin Branch.

"The Personal and Family Strength Research Projects: Some Implications for the Therapist" by Herbert A. Otto.

"The Mental Health Professional in the Community: Some Generalizations for Effectiveness" by Allen Hodges.

"Bilingualism: A Brief Review" by Kaoru Yamamoto.

"Foster Homes for the Mentally Ill" by Helen Padula.

"Developing Consultation Relationships with Community Agents" by Fortune V. Mannino.

"The Common Grounds Between Psychiatry and Religion" by Hector J. Ritey.

"Adjustment and Mental Health Attitudes in Foreign Students" by Arthur Nikelly, Mineyasu Sugita and Jack Otis.

"A Study of the Membership and Program of a Club for Expatients of Mental Hospitals" by Mabel B. Palmer and E. Lee Hoffman.

"An Analysis of Attitudes of Professional Personnel Regarding Mental Retardation as a Field" by Melville Appell, Clarence M. Williams and Kenneth Fishell.

"Shifting Patterns of Affection: Transitional Figures" by R. V. Heckel.

"The California Recovery House: A Sanctuary for Alcoholics" by Robert Martinson.

"Preventing Mental Ill Health in Early Childhood" by Ivor Kraft.

"The Concept of a Community Mental Health Clinic: Fact or Fiction?" by Michael J. Pacella.

"Contributions of a Speech Pathologist to the Psychiatric Examination of Children" by Clyde L. Rousey and Povl W. Toussieng.

"A History of Challenges in Child Psychiatry Training" by I. N. Berlin.

"Alcoholics Anonymous Principles and the Treatment of Emotional Illness" by Felix Cohen.

"Therapeutic Approaches in a Psychiatric Day Treatment Center" by Julian Meltzoff and A. A. Richman.

"Working with the Peace Corps: A Training Opportunity in Social Psychiatry," by Edward A. Mason and Gerald Caplan.

"An Oblique Approach to Clients with Behavior Disorders" by Robert B. Miller.

"Reactions of Children During Hospital Admission: Three Diaries" by Joseph Mayer.

"Functions of the State Mental Hospital as a Social Institution" by Robert M. Edwards.

"Natural Family Pointers to Foster Care Outcome" by H. B. M. Murphy.

"Remarks in Honor of Dr. William Healy" by Sheldon Glueck.

"Pets: A Special Technique in Child Psychotherapy" by Boris M. Levinson.

"Pragmatic Psychiatry and Traveling Community Mental Health Clinics" by Lindbergh S. Sata.

"A Perspective on the Function of the Psychiatric Halfway House" by Geoffrey A. Sharp.

"Psychiatric Role of Physical Medicine and Rehabilitation in the Third Revolution" by John Eisele Davis, Sr. and John Eisele Davis, Jr.

"Basic Issues and Problems in Attendant Training" by M. K. Distefano, Jr., and Margaret W. Pryer.

"An Evaluation of the Effectiveness of a Mental Hygiene Video Presentation on Adjustment" by Robert M. Blume, Sheldon Blackman and Jonah P. Hymes.

"A Note on Tolor's 'The Personality Need Structure of Psychiatric Attendants,'" by M. Powell Lawton.

"Is There Inner Strength for Mental Troubles?" by Ordway Tead.

"The Public Image of the Sex Offender" by Gerhard J. Falk.

"Discovering and Meeting the Mental Health Needs of Emotionally Disturbed Elementary School Children, with Emphasis on Children Whose Parents Are Inadequate" by Sol Gordon, Morris Berkowitz and Charles Cacace.

"Family Organization on a Modern State Hospital Ward" by H. Peter Laqueur and Harry A. LaBurt.

"Two Remarkable Achievements of Social Therapy: The French Psychiatric Hospitals of Saint-Alban and Lannemezan" by Paul Rajotte and Herman C. B. Denber.

"Attitudes and Opinions of Clergymen about Mental Health and the Causes of Mental Illness" by Richard F. Larson.

"Implications of Process-Reactive Schizophrenia for Rehabilitation" by R. E. Kantor.

"Effect of Physician Training in Mental Health Principles on Mothers' Appraisal of Child Health Conference" by Marvin Belkins, Edward S. Suchman, Daniel Rosenblatt and Harold Jacobziner.

"The Stigma of Mental Illness Can Be Erased" by Sister Loretta Maria.

"A Study of the Use of Mental Health Media by the Lay Public" by Alexander C. Rosen and Frank F. Tallman.

"The Integration of Community Psychiatry Training in a Traditional Psychiatric Residency" by Robert S. Daniels and Philip M. Margolis.

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I certify that the statements made by me above are correct and complete:

GEORGE S. STEVENSON, M.D.,
Editor

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Notes and Comments

PAUL V. LEMKAU, M.D.

Methodological problems in evaluating follow-up services to psychiatric patients

Since the introduction of concepts on the effects of isolation on the human being—which had profound effect in expanding theories of causation of behavior disorders and resulted in widespread changes in practices of child care—the most important contributions to psychiatric theory and practice have been in the field of patient care.

There is, however, a relationship between these developments, even though the first dealt with etiology and prevention, and the second with the care of the ill. In the first case, the concept was that social and emotional skills not learned in infancy or childhood might become permanently unlearnable; in the second, it was that social skills once learned are not permanent and that they can be lost rather rapidly unless kept in use. Both concepts are easily put into the context of learning theory.

Incidentally, the relationship of the two sets of notions seems to have gone un-

noticed by the framers of the Joint Commission on Mental Health and Illness who, many of us feel, rather unnecessarily deprecated the field of preventive mental health work in favor of very great stress on services to the already ill.

The preservation of social skills as an accompaniment and secondary goal of psychiatric treatment is very much in the forefront of thinking just now. Scientific advances set the stage for this in the work of Bender (1), Goldfarb (9), Hebb (11), Goffman (10), Bowlby (3), Lilly (14), and others. The developments of the ataractic

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and affect-controlling drugs during the same time period forced immediate, practical problems to the fore. It was not of much avail to suppress delusions and hallucinations or depression or elation with drugs only to find a person without clear-cut symptoms but also with no current knowledge of how to deal with the people and things of 1964. If you tried a two-step in a floor full of twisters you might feel a little out of place—at least I do!

The Joint Commission Report (12) reflects this kind of thinking in its stress on continuity of care, and in its presentation of a system of social and medical institutions to provide a smooth progression of services designed to meet the needs of people from the time they are diagnosed as ill until they return to the community. In general, the Report appears to despair of very many of these services extending beyond the administrative control of a service primarily psychiatric in its direction and management.

The Canadian counterpart, the Tyhurst Report, appears to be rather less parochial in its outlook (5). Its first call is for the integration of psychiatry with all medical care. Secondly, it stresses the objective of continuity of services from the place the trouble shows up—be it home or work—through clinic services, general hospitalization and its variants, regional hospitalization and, when needed, care in the specialized psychiatric hospitals. Its third basic recommendation is specifically for decentralization of services with eventual fractionation and dispersion of beds of the large mental hospitals. Great Britain's Mental Health Act, to a very large extent, stresses the same objectives.

The concept of continuity of care is the one with which this Conference on The Family in Mental Illnesses is most concerned. One end of the continuity is well-

cared-for: the mental hospital, with all its faults, is a recognized social institution. The other end of the series of continuous services has, until recently, stopped at the clinic door in the United States. There are gaps elsewhere in the chain of services, to be sure—day and night hospitals, regional hospitals or adequate general hospital services—but the main gap has been between the clinic door and the patient's place of abode or work. The care of people beyond the doors of clinics has not been the concern of many psychiatrists in the United States.

The developments suggested are getting attention now, and Muth's report (17) shows that although there is an enormous deficit in facilities, the ideas that must precede the development of the needed social institutions are being accepted. It seems justifiable to expect that what becomes established as a goal and ideal has a fair chance of becoming a part of practice.

This conference has been arranged to study one part of the scheme of continuous services, a part marked just now by a real spirit of adventurous reaching into the untried and unknown. In the past, this distance between the psychiatric hospital and the home has been left to clinics—which are usually planned far more on the basis of how much time the staff dares to spend away from the hospital or other base of operations rather than on the number of patients to be served. Although most people in psychiatry express a strong belief in the tenet that post-hospital care is often needed and would probably lengthen periods between readmissions, aggressive casework to pull patients into treatment is lacking, and rather notoriously so.

As a review of the group of experiments discussed in this paper shows, many of the efforts that are being made originate with public health organizations or with nur-

sing groups and are then supported secondarily by the psychiatric establishments. While one may deplore the lack of aggressive action on the part of organized psychiatry in the past, it must at the same time be stressed that when opportunity for an extension of activity presents itself, and when field personnel become available through the recruitment of professional and volunteer people in localities, psychiatry has gladly accepted the roles of consultant and helper in the operations that get underway.

Through the help of Miss Lillian Scally,¹ who shared her extensive collection of reports with me for the preparation of this paper, I shall review briefly the general nature of the projects now underway and attempt then to deal with some of the difficult problems in scientific evaluation associated with them.

The projects fall into certain groups:

The first is rehabilitation. In these projects there are generally two aims which, of course, are not by any means completely separable, although they do require different techniques, different kinds of people and different settings for the operations.

The first technique is social rehabilitation. This task, both in Canada and in the United States, is accepted by voluntary health associations to a very considerable degree. The aims of these programs include restoration of the social skills of people who may have lost them while in hospital, offering an opportunity to practice social skills and, finally, offering a secure place for the anomic person to feel at home before venturing into or while establishing his contacts in the "normal" community. There is much discussion of the extent to which these programs require professional leadership, but, in general, it appears that this function can make use of the healthy volunteer to a very considerable extent, both while the patient is in hospital and after-

ward when he needs practice after he is in the community.

The second aspect of rehabilitation concerns re-establishment in a work setting and in patterns of work. While working satisfactorily certainly requires simple social skills, it also requires special work skills which can best be gained when taught and supervised by specialists. Furthermore, it requires extensive contacting of possible employers who may need to be instructed in the tolerance that often needs to be entertained toward a patient during his period of re-establishment as a dependable worker. It may mean teaching skills and the delicate job of helping the expatient decide what field of work he would like to go into, and helping him reach a realistic compromise between his state of recovery, his inherent capacities and the opportunities available in his particular community. This task obviously is a highly technical one.

The Offices of Vocational Rehabilitation in various parts of the country have shown a most encouraging enthusiasm for grasping the many unfamiliar and sometimes frustrating tasks involved in the vocational re-education and placement of the person whose psychiatric symptoms have been suppressed, cured completely or at least sufficiently so that productive work is possible.

I have often pointed out that the concept of rehabilitation is actually a treatment procedure and that there is an important preventive aspect to it. The prevention of "de-habilitation"—the preservation of "habilitation"—is of the utmost importance. The keys to this aspect lie in brief, active hospitalization aimed at control of symp-

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toms before social and work skills are lost, and if long hospitalization is required, the presence of active, varied, paced programs within the hospital.

The second group of adventurous projects has to do with the transmission to the hospital of the facts of the patient's life in his community and his home before and during the advent of the illness for which treatment becomes necessary. Hospitals in England and public health services in the Netherlands have made this sort of investigation routine, employing "duly authorized officers," psychiatrists, public health nurses or social workers to carry out the function, depending on the situation.

In the United States, some hospitals are attempting "preadmission services" of their own, but the fact that such services usually can begin only after someone has reached the conclusion that hospitalization is necessary and that most United States hospital systems have not developed personnel in the neighborhoods of their catchment areas, makes the efforts both late and, often, inadequate.

Adventures in the more consistent use of local professional informants and investigators (in the scientific sense) are going forward. In Washington County, Md., the health officer and his nurses are involved in this sort of work (4). The preadmission clinic at Rosewood, Maryland's state hospital for the mentally retarded, is another such place. In other areas, the public health nurse is the person who gathers the local information and forwards it to the hospital.

It is in ways such as this that generalizations such as "social class" can take on meaning in the guidance of treatment planning for the sick individual. In a sense, one might say that psychiatry is

profiting and learning from the experience gained through the years in the treatment of tuberculosis contact investigations, and from the investigation of persons exposed to infection with one or another of the venereal infections.

Lest you recoil from association of the mental illnesses with the venereal diseases, let me remind you that one of the most demonstrable successful programs for the prevention of a mental illness lies in the tremendous reduction of psychoses secondary to syphilis.

The next sort of adventurous project lies in what has been called "keeping the doors of the home open" for the patient. Dr. N. Speijer of The Netherlands, who is in charge of the mental health activity of the health department of The Hague, furnished me a diagram that I find very useful in expressing this idea. He pictured the family circle as a circle, with each member occupying a part of the area within it. Mother's area might be proportionately large, father's somewhat smaller, and so on through the membership of the nuclear and extended family, each with his own "piece of pie" of the appropriate size. Now if a wedge is drawn out—a person sent to hospital for any cause—the circle contracts, absorbing his area to form a smaller family circle.

Speijer visualized the visiting person as holding the family circle open in its original form, reminding the group that there is someone who must be accounted for, even during his physical absence. It is as though the health visitor were substituting temporarily for the absent member, maintaining the group organization to keep him included. This sort of service was visualized as one of the aims of the Instructive Visiting Nurse Association project (19) in Baltimore, the project

which has furnished the opportunity for us to be here together.

Next in line comes emergency care. We—and the newspapers—regard it as downright scandalous when a hospital emergency room occasionally misses a diagnosis and sends a very ill patient home to non-medical care. Yet in many parts of the country we abide emergency rooms in hospitals placing patients whom they have correctly diagnosed as mentally ill in the hands of a nonmedical organization, the police. We seem so inured to this practice that it is hard to get either medical people or the public excited about it.

We can be encouraged that some of the adventurous projects are aimed at the proper medical management of medical cases. Again one must mention our own Washington County (4) activity and that in Boston (8). Both of these are following the lead of the now established practices in The Netherlands (13) and of those of some hospitals in England (15). Immediate medical care available in psychiatric emergency situations is an area that needs still further exploration in the process of adapting the European practices to the American social and medical scene.

One aspect of emergency services extended to the home of the patients, or to the place where the emergency occurs, has to do with family reacceptance. My friends in the Netherlands do not stress this point, but it seems to me that the fact that very few patients are hospitalized when their symptoms are showing violently, is important. When the family has seen the patient at his worst, and has seen that patient's symptoms brought under control before their very eyes; and as the family has observed the decision about further treatment made deliberately and during a period when symptoms are not obtrusive,

they gain a confidence in medical management not at all likely to develop when a struggling patient has to be manhandled by a couple of cops, or cowed by a lot of uniformed personnel.

The family can draw the conclusion that they have seen and withstood the worst and that, should it unhappily come about again, help will be available and they can again deal with the patient. A natural sequence would seem to me to be an easier reacceptance into the home. Since a neighborhood is but a large number of homes, the patient would be reaccepted into the community as well.

The health care of people in the community is a well-established practice in many fields—in maternal and child health, tuberculosis, diabetes, senility, cancer, etc.

Donnelly (6) remarks of such a service applied to psychiatric cases in Hartford: "It is important to emphasize that this was not a 'new' service for the visiting nurse agency, but a newly formalized one. A 1957 review of the total active caseload revealed that 65 patients with psychiatric diagnoses or severe symptomatology were currently under care. A review of the 1959 caseload showed that this number had increased to 140. Formerly these patients were given care under morbidity, adult or child health supervision service categories. At the present time there are 208 active cases of "psychiatric, other." When Montgomery County, Md., added the health supervision of formerly hospitalized psychiatric cases to its services, it found 30 per cent of those to be added were already being served by the health department.

In the United States it is fashionable to be very sanguine about the recoverability of all sorts of diseases. It is easy to forget that one of the greatest triumphs of medicine in the last century was the control of

diabetes, and that this has absolutely nothing to do with cure of disease but only with symptomatic control at the cost of constant health surveillance. While in psychiatry our means of control are by no means as satisfactorily specific as they are in diabetes, and our understanding of the physiology concerned in the control is very small in comparison, there is some comparability between the two.

We cannot influence as much as we would like the fundamental course of schizophrenia, or senility or manic-depressive psychosis or psychosis secondary to arteriosclerosis, but it is possible, with surveillance, to control some of the more bothersome and dangerous symptoms of these illnesses. Health supervision in such cases is obviously of paramount importance; continued treatment is the price of continued living in the community.

Treatment, of course, means more than seeing to it that the patient gets his drugs, although this is presently very important and bids fair to become more so as new drugs are developed and tested. The other aspects we have already referred to briefly, in terms of maintaining the family circle and establishing the patient in a social existence and in such productive work as he is capable of performing.

This involves more subtle skills than mere drug administration. It involves helping the patient remain in the strait-jacket of drug dependency without rebelling against the frustration of the realization that he is not wholly self-sufficient to deal with his symptoms. This is a not unfamiliar situation; it has been experienced for decades and longer with diabetics and particularly with epileptics.

The second aspect is the attainment by the family and others in the community of the ability to be helpful to the patient but not so overwhelmingly helpful that he

loses that area of independent action which his illness and its treatment leaves to him.

It needs hardly to be pointed out that such efforts must vary according to the diagnosis of the patient and according to his capacities and his history. Querido (13) clearly indicates that neurotic patients easily become too dependent for their own good, while psychotic ones often need protective surveillance, against which they tend to rebel. As was said above, the subtleties of health surveillance for psychiatric patients in the community stretch the knowledge of psychiatry and nursing and social work to their ultimate and cry out for the accumulation of experience and its proper interpretation for new methods. These methods need to approach better standardization than that implied in such terms as "clinical" or "interviewing" skill.

A characteristic of these varying adventurous projects has been the tendency to break down established definitions of the professions and what they should do. In England and The Netherlands we see psychiatrists freely making home calls. The distinctions between a public health nurse's mission and a social worker's mission, hard enough to draw in earlier times, fade out completely in the English and Dutch programs. The nurse doing health surveillance work with psychiatric patients in The Netherlands has certain rights to act for her clients as when they need welfare services, for example. Florida has seen fit to employ people called mental health workers, recruiting them from the nursing, social work or teaching professions. Psychiatric hospitals are trying to find ways of developing psychiatric nurses in ability in community psychiatric activity.

In Canada, one hospital has placed in the towns of its catchment area a locally

resident social worker whose job it is to smooth the communications and the passage of patients from the community to hospital and vice versa. The Hartford study (4) found it wise to establish the position of liaison nurse for much the same purpose. They have also experimented with volunteer aides to the nurses as the latter carry out their health supervision of psychiatric patients.

The implication of all this seems to me to be that our established professional lines break down now because we are teaching a task somewhat different from that in which the professions became established. What I have called these "adventurous projects" force to our attention the need for redefinition, perhaps for the abolition of some of the old professional delineations, so that new aims may be reached. This situation presents a dilemma because carefully evolved educational and experience standards for the professions suddenly no longer fit the case, and we are at a loss to know how to provide both the needed varied services and at the same time assure that the standards of medical care will not be lowered to levels of risk of bad practice.

Now that these various projects are before us, in outline at least, it is time to approach the real subject matter of this discussion, the methodological problems of evaluation. A review of the projects reveals two main approaches to this issue. The first is qualitative, clinical or impressionistic; the second is quantitative, based on such criteria as the number and length of readmissions, the number of patients returned to former living quarters or jobs, etc.

To begin with, perhaps it is well to point out something which seems, to me at least, to be important; namely, that these are not really two separate methods, but that they use two different kinds of computers in

reaching conclusions. The first, the qualitative methodology, depends on the processes, conscious and unconscious, of the human brain as a computer. The brain is capable of absorbing into its formulae for the solution of problems an enormous number of engrams, weighing each as it does, and working through—in ways that still baffle the neurophysiologists with their complexities—to a conclusion. The process makes one stand in great awe, particularly when he is faced with the hope of analyzing the process through the pedestrian abilities of even the most complex computers. For these, values of bits of data must be assigned before they can be combined in processes which can lead to conclusions.

The difficulty arises, of course, that when a brain does its complex weighing and comparing we can never be sure that the data are not distorted by the conscious or unconscious processes the brain has performed in the past. No two artists see exactly the same things to paint in the same landscape or the same face. Qualitative evaluation of projects has precisely the same difficulty. War painted by Picasso appears quite differently from war painted by Delacroix; these differences leave the scientist suspicious when one psychiatrist, Bierer (2), finds the Amsterdam experiment having failed, while others find it an outstanding success. The scientist can also see things very differently, depending on his skill as an artist when he essays qualitative evaluation.

The same difficulties obtain when one makes evaluations on the basis of consensus of opinion. Dr. Alan Miller attempted to get an evaluation of a conference something like this one six months or a year after it had ended (16). He sent questionnaires to all who had attended and received an overwhelming proportion of re-

plies saying it had been an excellent conference, indeed. But some did not reply. To these he sent a second letter and got a number of approving replies, but a sprinkling of negative, critical answers appeared. He persisted in pestering the "non-repliers" with registered letters and finally with telegrams. With each more urgent type of communication he got more replies—and a larger proportion of replies saying that the conference was, in the opinion of the writer, a failure.

The conclusion of these late repliers seemed to be that Dr. Miller really wanted to know what they thought and that if he wanted to know that bad, they would certainly tell him, even if what they had to say was unfavorable. The lesson this teaches is very plain, that asking for evaluations at the end of a meeting, and collecting them haphazardly, is a rather useless evaluating device. It takes more than a simple invitation to get the really critical answer.

In using the consensus as an evaluating device, it is certainly most necessary to keep in mind that the easy answer to get is the approving one and that special motivating procedures may have to be used to get the less common but often most useful critical comment.

In my estimation there is another aspect of the qualitative method that needs special stress. This is evaluation that does not attempt to compare two things or procedures, but rather attempts to describe one very accurately and in detail. This is the method used by the anatomist who is satisfied when he has found ways of getting another to visualize a muscle, a bone or some other organ exactly as it is, or, to be more precise, exactly as his trained eye is able to see it. This is the naturalist's approach as he describes a bird, a shell, a leaf—or a way of life of a human being. This

method is not really evaluation but the background necessary before evaluation can take place. Two birds can be compared only after each is thoroughly described. This is the methodology used and defended by Ozzie Simmons and his colleagues (7).

After finding out and describing how ex-hospital patients actually lived in the community, they could reach some comparisons about what sorts of patients survived best in the community, in which sorts of family settings. Their first goal, however, was to describe various ways of living and only after this were the evaluative comparisons attempted, and then only tentatively.

The problem of repeatability of judgments—reliability—also gets into qualitative methods of evaluation. There are good methods available for testing reliability of many types of judgments and probably nothing more needs to be said about this issue other than that it takes a good deal of nerve to submit one's own judgments to the rigorous methods that have been devised. They often make the clinician appear to be an awful fool, and nobody likes to risk that sort of result.

On the other hand, reliability studies sometimes can be reassuring; Vera Norris (18) found in her study, for example, that two different psychiatric hospitals diagnosed 70 per cent of the same patients in the same way which, after all, is not too terribly bad and would leave some margin within which really gross differences in two groups of patients could be detected.

Another difficulty of qualitative evaluation is that inherent in the passage of time. Neurotic cases in World War I could be identified frequently because they had gross hysterical symptoms. By World War II, styles had changed and gastro-intestinal malfunction was a much better index of neuroticism among soldiers. We have

been studying a syndrome that seems to have been present in certain parts of Croatia and Dalmatia for a number of decades at least, but we are very fearful that time may change the fashion and we will one day find ourselves having put in years studying an ephemeral fad rather than a fixed type of reaction pattern.

It is disgusting to a researcher studying patterns of suicide by gas inhalation when natural gas is introduced and the stuff will not kill people nearly so quickly as when manufactured gas was in use. I exaggerate, of course, but only to point out one difficulty of before-and-after types of evaluation. The other main difficulty, of course, is the fact that the judge does not stay constant over the passage of time, either.

There is much more that may be said about the difficulties of qualitative methods for evaluation of programs or procedures or cases. They can be summed up as difficulties in being sure that valid data are reliably judged. Absolute assurance is usually unattainable, yet the computer that is the brain appears to be the only instrument really capable of analyzing unorganized observations and muddling through to reasonable conclusions. Most of the accumulated knowledge of the human race in general, and of medicine and psychiatry in particular, has been arrived at by qualitative methods; in some cases it is later found to be subject to "proof" by quantitative methods.

It does seem important to stress the aspect of qualitative evaluation I have identified above as the naturalistic method. To learn accurately to describe what exists in all its ramifications makes it possible to compare across time or space.

The quantitative method is often looked upon as the savior from the pitfalls of qualitative method. The key to this method is to pick out certain modules of

information which are small enough so that their limits are easily definable. When a long or short series of such modules has been gathered they can be assumed to be samples of characteristics of the universe from which they are selected so that their combination will give a useful, if not a completely accurate picture of the whole with which the researcher is concerned. Then the modules present in one series of wholes can be compared with another series of wholes made up in part, at least, of the same modules, and a comparison can be drawn.

The effect of manipulation of one sort or another in one group can be tested by whether or not the data modules have changed in comparison with another group which has not been exposed to the manipulation. If the modules of information are small enough and are clearly defined and if they really represent significant samples of the whole, the scheme is not subject to scientific attack. The difficulty lies in defining the module and in its representativeness of the whole, as well as in the enormous numbers of modules necessary if one is successfully to describe something as complex as a human being living in society. This problem seemed much further from the possibility of solution a few years ago, than at present, when computers are capable of complex multiple correlations and factorial analyses done in practically no time at all.

In evaluating a simple statement such as that "before a rehabilitation program was introduced 40 per cent of schizophrenic patients returned to hospital for readmission within a year, while after it was instituted only 20 per cent were so readmitted," the complexities are, of course, enormous. To be sure the two groups were comparable, modules of information about age distribution, sex distribution, social status,

diagnostic reliability, education, prior work record, etc., etc., need to be known.

In earlier times, scientific logic did not demand such vigorous testing and, for some purposes, it is not now needed. But we have new insights into the enormous variability of human beings. The more we recognize this variability, the more modules of information must be included to describe the individual or the group, and the less comparable they are seen to be. We are reduced to the common problem of having cells in the master table with numbers in them too small for statistical use, and we are forced to curb our appreciation of differences or go get more cases—which is usually too expensive to do.

Furthermore, we are working in an area in which really large differences are not to be expected. It has been pointed out that even the most intensive sort of psychotherapy occupies only about 5/112 of the waking hours of the patient. And we are tinkering with a used motor, not installing a new one. And often we do not know what the trouble is; we are only sort of hitting with a tack hammer, hoping to dislodge a block somewhere in the machine. Under these circumstances we are more likely to be dealing in shades of gray rather than in black and white.

This concludes my critique of methods of evaluation available to us. In spite of the many difficulties of all the various methods that I have suggested, I do not think there is reason to be discouraged. Nor do I think we should stop trying to apply what we know about methodology of evaluation to our various programs and procedures. Qualitative and descriptive methodologies have value and in an increasing number of cases, and with the computers that have so much relieved the restrictions on the number of items of information that can be dealt with, it seems

to me that we are closer to good evaluative methods for psychiatric programs than we have ever been before. I see no reason for avoiding a job just because it is hard!

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Working with the Peace Corps: A training opportunity in social psychiatry

Psychiatrists from Departments of Psychiatry throughout the country have been involved in the selection and training programs of the Peace Corps. Their professional interest and generous participation have matched the enthusiasm of the volunteers in this global opportunity for a "people to people" program. The Peace Corps is unique in its melding of significant service to people in other lands, with a simultaneous service to our own people through the enrichment of the lives of the

volunteers and the international understanding these volunteers will induce among others in our nation.

Rising to the challenge of the many theoretical and technical problems with which they were not accustomed to dealing in traditional clinical settings, the psychiatrists not only have been willing to serve; they have also responded vigorously to the demands of the program. These psychiatrists were called on to make assessments of normal young men and women and to participate in the selection of those volunteers most likely to perform well under future situations only partially known.

This challenge imposed considerable demand on the psychiatrists' adaptability and resourcefulness. There were many stresses for these psychiatrists, not the least of which was the time pressure. This urgency, together with a refusal to be saddled with red tape, made the Peace Corps distinctive. The psychiatrists, like other specialists, responded to the mobiliza-

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tion of effort for a new frontier of service. They moved away from familiar clinical surroundings, entered social systems which were unfamiliar, and joined staffs which generally had never before worked with a psychiatrist. It was necessary for them to work out a mutually acceptable role and to interpret this to educators, selection personnel, and to the trainees.

This task was complicated by the novelty of this role. It required the knowledge and skills involved in the psychiatrist's individual therapeutic effort with patients, which are recognized to be of primary importance; these were applied to new work in a subsidiary role with an essentially healthy group in regard to job placement and mental health teaching for effective overseas service.

The Peace Corps, recognizing the need to assist the psychiatrists in developing their emergent role, has invited the help of community mental health specialists because of their emphasis on prevention and their skills in the collaboration between psychiatry and education. A manual¹ was written in May, 1962, which formulated some principles and practical steps to guide the psychiatrist as he approached this new task.

Some parts of the manual had been tested at various Peace Corps training sites, and these early experiences lead to revisions in the material concerning the mental health instructions. Other areas of work had been so recently changed when the manual was written that it could not be based as much on actual Peace Corps experience. For example, in the handling of assessment interviews a policy decision had just been made to limit these to trainees about whom there was some question. Therefore, the potential difficulties had to be extrapolated from experiences involving the work of the psychiatrist in

schools, colleges, public health units, and industrial settings.

Besides distributing the manual, the Peace Corps invited each psychiatrist chosen as consultant to a training program to attend a two or three-day training institute at which he could anticipate the problems in his approaching duties and absorb background material from the field of preventive psychiatry. The participants received orientation and content of practical value; in addition they were taking part in the development of a special reference group to which they could form an allegiance.

From the Peace Corps Administration they would draw part of their support by way of official policy and over-all program goals. From the training site and its director, each psychiatrist would draw his authority and his assignments and receive his pay. As members of a specialty, each had his professional reference group in the general field of psychiatry. But because of the lack of structure and tradition in his new position, he needed the additional professional backing which derived from the interaction with his colleagues during and following these institutes.

This allegiance has been carried forward by means of communications from the Peace Corps central office psychiatric staff, and by such meetings as the National Institute of Mental Health and Peace Corps jointly sponsored in Washington in March, 1963, entitled "Peace Corps and Behavioral Sciences."

As any profession embarks on a new course, it suffers the conflict and developmental pains associated with transition. There are pressures from at least two directions: from within, the profession feels

¹ Caplan, G., *Manual for Psychiatrists Participating in the Peace Corps Program* (Washington, D. C., Peace Corps Medical Program Division, 1962.)

certain doubts that it is equipped to take on a new role, and from the social system there are forces trying to maintain the equilibrium and to exert pressure on the profession to remain inside its traditional boundaries.

In spite of its enthusiasm about the aims of the Peace Corps, psychiatry is experiencing such doubts. Is it really feasible to teach volunteers mental health? Is it practicable to make assessments of future response to stress? How can one preserve the essential degree of confidentiality?

As the new professional role emerges, there are inevitable and useful questions raised, trials and errors made, and gradual consolidation based on common experience. But the Peace Corps psychiatrists were scattered across the country and would have been subjected to these pressures individually if there were no affiliation with their counterparts in other programs to resist some of the pressures and maintain morale. The training institutes have provided the allegiance to the new orientation.

At the institutes there were representatives of all schools, all geographical areas of the country, and all levels of experience. Those still in residency programs were brought together with senior psychiatrists so that all could co-operate in the development of a new allegiance. It would have been inappropriate for the institute leaders to assume the usual teacher role.

In addition, since there still is no scientific proof of the validity of certain community mental health principles and one cannot be sure they would all be appropriate to the Peace Corps, the material could not be conveyed by ordinary lectures. Instead, the leaders adopted an egalitarian approach and tried to promote an atmosphere of joint learning. Under such circumstances they became resource persons rather than teachers.

Naturally, a three-day institute could not teach the range of professional knowledge necessary for a thorough understanding of preventive psychiatry. Its goal had to be limited to the maintaining of motivation and the supplying of orientation, illustrative material and practical suggestions for initial field activities. As these psychiatrists moved into their training sites and found unique qualities about each, they had to use their own resources to adapt to the needs of that site while maintaining a certain amount of consistency and uniformity among the various programs in order to give the principles a fair test.

It was not thought necessary to cover in the manual or the training institutes such topics as interviewing techniques, problems of diagnosis, or management of discussion groups. The primary focus was on other areas less familiar in traditional psychiatric training, such as the following:

One of the most important issues was the definition by the psychiatrist of his role; this was considered by many as the most complicated and least traditional. There was a minimum of difficulty in connection with the identification and selection-out of any trainees with mental disease. The psychiatrist felt and was clearly ascribed sanction for this activity, and also for the mental health training for which he was responsible.

Less structured were the aspects of his duties which called for him to interact with trainees and staff as supportive counselor, adviser on job placement, or consultant about administrative matters which had mental health implications. If a psychiatrist feels he is "imposing" himself on persons who resent intrusions and whose mental health they fear he "jeopardizes," he sometimes tends to withdraw to a more immediately acceptable role. It is necessary of course, not only to understand and

accept the combination of roles, but also to explain it to others.

The psychiatrist must obtain sanction through repeated discussion and clarification with the key staff, primarily the project director. He must make special effort to explain his orientation and to move in steps appropriate to the pace, tolerance, and over-all needs of the program. In most instances, the apparent conflict in roles between that of the selector and of the confidant has not been troublesome. Some persons had anticipated that no trainee would confide in the psychiatrist if such material might negatively influence the selection board. The role of selector can be as unpopular with a psychiatrist as with any other staff member when it comes to rejecting a trainee. Nevertheless, proper selection is in the best interests of the volunteer and the Peace Corps, and the psychiatrist learned to accept this as a primary responsibility.

It was interesting that anyone who felt over-identified with the trainee or insecure in his unaccustomed combinations of roles, usually retreated (or regressed) to his familiar role as diagnostician or therapist, with the rationalization that this was the only "sensible and rational" role for a psychiatrist.

In order to build the optimal relationships between psychiatrist and staff, it was recommended that he use every opportunity to promote interaction. By spending time meeting with the staff before training begins and during subsequent regular meetings, by sitting in on classes, socializing at mealtime, and by working in space which facilitates mutual contact, he has the opportunity to convey his wish to contribute in a positive way, to demonstrate his competence, and to win the trust and respect of the staff.

Inevitably there are negative stereotyped expectations. Psychiatrists are accustomed to being tested with jokes in social encounters or to dealing with transference distortions in patients. In the Peace Corps there are the usual varieties of irrational preconceptions about "mindreaders" and "magicians." The psychiatrist had to learn to avoid the role of therapist to his colleagues in order to dispel the notion that he is always ready to "psychoanalyze" others whether they wish it or not.

If he strikes an appropriate balance between revealing something about himself and maintaining a professional reserve, if he makes contact with other staff members without allowing them to feel he is going to trespass on their teaching or administration, and if he makes an effort to learn the behavior and language cues of the staff so that he can communicate adequately, he will have a maximum opportunity to establish the optimal image of psychiatry.

The social system in which the training takes place has characteristics, boundaries, patterns, tensions, and forces which are influencing each other. Some elements are more important to the work of the psychiatrist than others and he must familiarize himself with these key persons or patterns. Since he spends only about one day per week at the site, he must be alert to the cues which indicate that the system is under strain, and he may be able to make use of such information in the mental health training or alert himself to the possible need for preventive action.

With the trainees, as well as with staff, the psychiatrist must build satisfactory relationships. The trainees already feel under constant surveillance and they may see the psychiatrist as a further threat. If he explains at the outset that his job includes lecturing, selection, and counseling,

and if he openly and explicitly informs the trainees whenever he is interviewing for selection purposes and keeps confidential that which he promises, the trainees will respect him and accept the atmosphere of evaluation as part of reality. The psychiatrist should come to an understanding about his own feelings in these issues so that he may be relaxed and natural, and thus help the trainees deal with their anxieties about being watched over during training and in their jobs overseas.

During the five hours of mental health training there is an opportunity to consider a representative sample of psychological stress situations likely to be encountered overseas. The rationale of anticipatory guidance is that having considered feelings and behavior in advance, one will be better-equipped to cope with the stress when it occurs.

Naturally, there is little value in a purely intellectual exercise predicting possible events. However, when the trainees are guided toward developing an awareness of their responses to current stresses, these can be more deeply learned and more effectively associated with the challenge overseas. In the short time available, if the psychiatrist concentrates on the message that awareness and/or acknowledgment of negative feelings is *not* synonymous with weakness or illness, such an attitude should help the volunteer in any job assignment.

It will be difficult to isolate the contribution of any single element of the Peace Corps psychiatric program. The impression is that the teaching materials and institutes were worthwhile, but that they will need to be revised, or other supportive activities substituted as the program matures and more is learned about the specific demands on the volunteers. With the efforts of the National Institute of Mental Health, in conjunction with the

Peace Corps, communication among psychiatric personnel is being promoted.

Follow-up information on the overseas adjustments of the volunteers should be supplied to the psychiatrists, and they should also be informed about Peace Corps developments through some periodic bulletin. They have fully committed themselves to the program, and their allegiance should be recognized and maintained.

In summary, we recognize many concerns and problems as psychiatry moves out of the clinic into the community. Although the traditional roles and skills must be maintained, the profession now has the opportunity to explore new roles and new skills in the field of social psychiatry. In the Peace Corps the psychiatrist encourages the trainees to confront reality, and psychiatrists must not avoid it themselves.

Psychiatry already has a certain amount of knowledge about nonpathological human behavior; it has a conviction that an individual and his environment are mutually interacting; and it has an optimistic orientation about the capacity of individuals and groups to move and be helped toward greater maturity. In the Peace Corps, psychiatry is learning more in these areas which have important implications elsewhere. Such knowledge can be put into practice immediately: the proposed National Service Corps is one example.

Work with the Peace Corps is a high-status opportunity for psychiatric residents to be trained for the developing field of social psychiatry. Much of what has been learned in preparing psychiatrists for community practice in the Peace Corps is directly applicable to the preparation of psychiatrists for the increasing nationwide demands of community mental health practice which are following the new federal programs in our field.

The nurse-patient relationship in a general hospital

In the course of a normal hospital day, the average patient, lying in bed seeking rest and quiet as he struggles to regain his health, may have a dozen or more casual visitors.

In random and haphazard sequence, there trail through his room the social worker, the orderly, the dietitian, the x-ray technician, the ward maid, the intravenous nurse, the occupational therapist, the laboratory technician, the chaplain, the volunteer from the hospital store, the physiotherapist, the admitting nurse (with his bill), the clerk from the insurance office, the newsboy. If they are fortunate, his family and friends may find a few minutes to visit with him, and his doctor is almost forced to make an appointment for a consultation.

Behind this kaleidoscope of strange and familiar faces there stands the nurse. Dur-

ing any one eight-hour shift she is always there, always the same person, always ready to give help when the patient really needs it. Her relationship with the patient is, then, a special one; at the same time this relationship has special assets as well as potential liabilities. It is our task here to examine certain aspects of that relationship,

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to understand the factors that enter into it, and to see how it may be used for the patient's benefit.

Let us begin by observing a man of 43 who had been admitted to the hospital for back pain that had kept him out of work for the two-and-one-half years that had elapsed since an accident. During an interview with the consulting psychiatrist, the patient spoke as follows:

Dr. "Well, how are things with you?"

S. "Well, it started off bad this morning. I was down in the x-ray room . . . my back was aching some. Of course, I don't blame it on the guy at the x-ray, you know, but he wanted wanted me to bend . . . so I bent forward and backward and it started hurting, you know . . . so that's it. (Pause) You got to stand some pain, you know, if they're going to find out something. I mean, I don't mind that. I get burned up sometimes, that's all. Some of the nurses they got up there, Christmas! They have better doctors here than they have in Worcester, but I can't say that for some of the nurses up here."

Dr. "What trouble do you have with them?"

S. "Well, in the morning they don't have to bother with me. I mean, I get out of bed and go down and take a shower, and they don't have to get me this or that. A lot of times I think I've saved them a lot of steps. . . . The only thing they do is bring in my meals. Sometimes I'll even bring the tray out. There are some nice nurses here. Some of them ask me if I want a backrub, and if I see they're busy, I say 'never mind it.' Like this morning, I really need one, see, so around nine o'clock the nurse wasn't there, so I asked one of the girls at the desk if she would give me a backrub. She said 'Yeah,' but I said if they're too busy, never mind. I don't like to bother them, and I don't like to be crying every time my back aches.

"So there was one nurse working around this morning and every half hour she said she'd get around to rubbing my back. I said 'That's all right.' Cripes sakes, it came around one o'clock, and I still didn't get it, so I got disgusted.

"You know, I thought if I got my backrub this morning and lay down the rest of the

morning, I might have been all right to come down here this afternoon. But about one o'clock I said, 'the hell with it.' So I went up on the roof. In fact I even felt like going home."

Dr. "You felt pretty bad about this, this morning."

S. "Well, I mean, you know, if I was a guy that stayed in bed and kept groaning for every little thing, I'd expect them not to show up. . . . All I ask is to get my back rubbed once in a while. Them aspirins don't do any good. Of course, I asked for two more aspirins this noontime. They asked me when I had the other two, and I said I didn't know. 'Sometime this morning,' I said, 'You might as well get them anyway; it's quicker than giving me a back-rub.' But that didn't do any good . . ."

Dr. "You felt pretty bad about this, this morning."

S. "Well I did, yeah. I mean, that's the only thing I ask them to do"

Dr. "What was the feeling that you wanted to go home?"

S. "I got disgusted. I'm getting disgusted."

Dr. "What do you mean exactly by feeling disgusted?"

S. "Well, maybe I get half disgusted and half mad. Like I say, that's all I ask them for—Cripes sakes—to rub my back. . . . My back aches, but I don't holler for aspirins all the while, because I don't care about being doped up, you know. . . . If I try aspirins and it don't do me any good, there's no sense in asking for them. So I stand it. But when it gets to a point where, you know, it hurts me bad, well, I thought maybe they could relieve it. So I was mad . . . I was mad enough to go home, and then I figure if I do go home, why I'm not gaining anything by it, you know."

Dr. "What was the feeling about going home?"

S. "Well, I just wanted to get out of here."

From what the patient says—although he is somewhat hesitant and apologetic in saying it—it is apparent that he is smoldering inside at the failure of the nurse to comply with his request for a backrub. He has controlled his behavior, but his inner thoughts reveal the depth of his emotion; he was

strongly tempted, in his "disgust," to leave the hospital and go home. One can understand how he might feel disappointed, even mildly annoyed in this situation, but that a mature man should be angry enough to feel tempted to leave the hospital and give up his treatment is surprising.

The quality and intensity of his emotional reaction becomes even more surprising when it is placed against the background of the patient's image of himself as a person and of his behavior before his injury. In the course of talking with the psychiatrist, the patient told a great many facts about himself. He had worked the larger part of his life as an operator of huge construction equipment—cranes, bulldozers and steam-shovels. He gloried in this kind of activity, and prided himself on being a person who sought out the hardest, most dangerous jobs, those no one else could do. He liked vigorous work and long hours; sometimes he gladly put in 14 to 16 hours a day, 7 days a week, on projects that had to be completed in a hurry. He almost never took vacations, would never leave work for minor illnesses, and prided himself on his ability to withstand the pain of injuries sustained on the job.

He found the role of patient a distasteful one. He resented being forced into the position of being dependent on doctors, nurses and others for medical attention, on the insurance company for compensation, on his lawyer for advice. This conflicted with his patterns of behavior during his entire previous life.

As a boy he liked to work to make his own spending money so that he would not have to ask his parents for it, and throughout his adolescent and adult years he had proudly maintained his independence of everyone for everything. If he needed something, he would get it for himself; he would never consider borrowing from others or asking

for anything; he would go without rather than resorting to a position of dependence. Even during a brief period of unemployment, he refused the governmental unemployment insurance due him, since he considered this charity.

We are faced here with a seeming paradox: On the one hand, the patient professes to be an independent, self-sufficient person; on the other, he desperately wants help in the form of a backrub, and is made so angry when it is not forthcoming that he is sorely tempted to leave the hospital in disgust. How are we to understand the coexistence of these conflicting feelings within the same person?

To approach an answer to this question, let us first note that the patient's injury holds a key position. Before his accident he had, in fact, been the kind of person he described himself as being. All of his life he had been active, vigorous, strong and independent. It was only after his injury that signs of demanding dependency appeared in his behavior.

Furthermore, when we reflect on his patterns of behavior before he was incapacitated, it becomes apparent that his attitudes, his activity, and his independence have an exaggerated quality. Most people do not drive themselves so mercilessly; most people can allow themselves at times to depend on others for help in the give-and-take of human relations; and few have to insist so relentlessly and vigorously on their self-sufficiency. When, however, one explores the personality of those who exhibit such exaggerated characteristics, one discovers that there exists beneath the surface a strong tendency pulling in the opposite direction; that is, a strong need to be dependent and to lean on other people for help, guidance and emotional support.

Under ordinary circumstances, however, the person is not aware of these dependency

needs; in fact, he would be very much distressed if he were to recognize them, since, for him, to be dependent in any way is to be weak and inadequate and to fall short of his ideal image of himself as a person. He cannot tolerate the idea of being dependent, nor can he have any sense of self-esteem unless he is active and self-sufficient.

What is more, he controls and keeps hidden the unwanted and distressing tendency to dependency by consistently maintaining his independence, by leaning over backwards, so to speak, to be the opposite. It is this psychological defense mechanism against dependency (termed *reaction formation*) which provides the quality of exaggerated independence in his behavior and personality structure.

Although we have called this pattern of self-sufficient independence a "psychological defense," it is, in its own right, an asset to the person who exhibits it. For it has, in reality, allowed him to be an active, effective person, conscientious, reliable, a good provider for his family, a help to his neighbors, and a valuable employee. At the same time, it makes him especially vulnerable to difficulties of a psychological nature when he is faced with a serious and incapacitating injury or illness. The reasons for this are readily apparent, if we reflect on the effects that follow on such an illness.

In the first place, an incapacitating injury or illness forces the individual to abandon his activity and self-sufficiency; that is, the defenses with which he has controlled his dependency are forcibly wrested from him. In the second place, his underlying dependency is invited into open expression, not only by his very real need for medical and nursing attention, but also by the tendency of families and friends to offer solicitous attention and help to the invalid. In other words, there is a two-pronged attack on the equilibrium of psychological forces that had

constituted the patient's personality structure before his incapacitation.

As a corollary, the patient's relationships to other people are changed. Whereas previously he had been able to maintain his independence of them and to keep a good degree of emotional distance, he is now forced into the position of relying on them for his wants and needs. In this new situation disturbances in his relationships may occur, particularly with those people who are in an important caretaking role for him.

One of the most important of the caretakers is the nurse, since, as we have mentioned before, during the patient's often extensive hospitalizations, it is the nurse who has the most prolonged, constant and consistent contact with him. For this reason, the nurse is liable to bear the brunt of his emotional reactions to his invalidism, but by the same token she is in a central position to provide a therapeutic relationship for him. Let us therefore examine two important psychological complications that occur and the nurse's part in combatting them.

As one might predict, a person with the psychological structure we have been describing may either rebel against becoming a patient or may play the part to excess, depending on whether his defense of excessive independence or his underlying excessive dependency needs are ascendent. Let us consider the former situation first.

One sees a number of patients who, despite a need for bed rest, medications, diets and other therapeutic regimens, refuse to follow the treatment plan prescribed for them. This is at times a puzzling phenomenon to observe, for one would expect common sense to tell the patient to conform to the medical program set up to restore him to health. Fortunately, most people faced with an illness are able, temporarily, to give up their independence and autonomy and

to accept the degree of dependence required to get well. The patients we are concerned with here, however, do not have that flexibility of personality structure. Goaded by their fear of a position of dependency, they are unable to relinquish the necessary amount of independence, even though their physical recovery depends on it.

In such cases the nurse finds herself forced to cope, for example, with the coronary patient who refuses to stay in bed or stop smoking cigarettes; the man with the duodenal ulcer who will not stick to his diet; or the diabetic who objects to taking his insulin. What is more, she may be subjected to a certain amount of abuse and anger when she tries to put into operation the orders the doctor has entrusted her with carrying out. The patient, of course, is reacting to being forced into a dependent position and against the person who not only, he feels, is forcing him, but on whom, as a patient, he has to depend. He tries, therefore, to maintain his autonomy; in doing so he often behaves in an antagonistic and difficult manner which may be quite different from his usual behavior with others, when he is in a position less threatening to his self-esteem.

In managing such patients, it is important for the nurse to understand the emotional stress to which they are being subjected. In the first place, this will allow her to treat his seeming stubbornness and aggressiveness with tolerance and objectivity when she realizes that his actions are not directed at her as an individual person, but as a representative of all the caretaking personnel who (the patient feels) are forcing him into a dependent position.

Furthermore, recognizing that dependency is anathema to the patient, she will allow him to be as free and self-sufficient as the situation permits and will respect his dignity and self-esteem. Even in those areas

where the patient is forced by his illness to remain inactive or to give up autonomy, instead of ordering him passively to comply with restrictions, she will try to invoke his *active* participation in the treatment—to get him to take responsibility, for example, for staying in bed—making his difficulties appear to be a challenge that he must courageously overcome.

In yet another way the nurse can be of help to the patient who is fighting the role of invalid. Many patients of this sort, fearing that a revelation of symptoms to their doctor may lead to a diagnosis of serious, crippling illness or to a delay in their discharge from the hospital, fail to mention them to the physician. On the other hand, as they get to know the nurse, in their intimate contact with her, they will divulge the secrets that are worrying them. The nurse is, then, in a position to advise the patient's doctor of the difficulty, leading either to reassurance to the patient that his symptoms are not serious, or to the treatment indicated for these symptoms.

A failure to discharge this responsibility can have serious consequences. A woman in her early fifties, for example, while hospitalized for an unrelated condition, confided to her nurse that the nipple of her left breast looked strange to her. The nurse replied, "Why's that's nothing more or less than an inverted nipple." The patient, falsely reassured by what she took as an authoritative pronouncement, continued to deny to herself her concern over the lesion in her breast, which over the next year and a half became ulcerated and began to drain. During the entire time she never mentioned it to her physician, and when it was finally discovered, she had fatal metastases from a far advanced carcinoma of the breast. Had the nurse at that time informed the doctor of her observations, it would have counteracted the patient's pathological denial and

might have been instrumental in curative early surgery.

So much for the patient who fights too hard against the dependency imposed by his illness. Let us now turn to a consideration of those who show quite the opposite form of behavior, those who manifest what is called a *regressive reaction*.

Such patients pose problems in management that are among the most difficult that nurses and doctors have to deal with. They are familiar to all of us. These are the patients whose complaints and incapacity are way out of proportion to the severity of their physical lesions. They remain totally invalidated long past the time, when, as far as the state of their illness or injury is concerned, they should have resumed full activities. What is more, they are full of little demands for help and service from nurses, doctors and families. Not only do they give the appearance of almost total helplessness and incapacity; they are also prone to angry complaints and seemingly peevish criticism of the hospital staff when they are made to wait for help, or when help is not forthcoming at all.

Despite such behavior, most of these patients stoutly proclaim that they want to return to vigorous activity and complete self-sufficiency. And indeed, as we have seen, prior to the onset of their disability, they had been exceptionally active, effective and independent people. What has occurred in these regressive reactions is that the underlying dependency has escaped the control of the defenses that once kept it in check; now using the symptoms of the illness or injury as a seemingly legitimate excuse, the underlying dependency prolongs those symptoms as a means of satisfying the long-hidden dependency needs. A new psychological equilibrium, with dependency in the ascendancy, has replaced the old, and

what started as a physical illness has become prolonged by psychological complications.

It is important to remember that the replacing of the previous self-sufficiency by the new pattern of helpless dependency does not ordinarily take place all at once. On the contrary, it usually requires a period of days to weeks to occur, and the behavior of those caring for the patient can have an important share in either promoting or preventing the reaction.

The too-cautious physician who overdoes bed rest and inactivity, the nurse who tends to coddle and protect her patient, families who are overly solicitous and helpful, lawyers in compensation cases who urge their clients not to go back to work until they are completely symptom-free—all these tend to foster the emergence and the gradual dominance of the dependency needs. And once the new and pathological equilibrium is established, it is often very difficult to reverse it and to get the patient to return to activity.

Here is truly an instance where an ounce of prevention is worth a pound of cure. The nurse, because of her unique opportunity for repeated, close observation of the patient during his hospitalization, is often in the best position to observe the first signs of the development of the regressive reaction, and to alert the rest of the caretaking personnel to remedial action.

Before considering more specifically the ways in which the nurse can contribute to the prevention and management of these problems, let us briefly observe an illustrative patient.

Mrs. F, age 38, had always been the mainstay of her family. Not only had she held a part-time job to augment the family income; she had also managed her own household in every detail. Moreover, she was a strong figure for her family and neighbor-

hood friends, providing advice and moral support whenever it was needed, and priding herself that others came to her for help while she herself was entirely self-sufficient. In the course of events she developed a protruding intervertebral disk which required hospitalization and surgery. She faced this ordeal stoically and calmly, both preoperatively and in the days immediately following her operation. Then one day it was noted that she was anxious, somewhat tearful and depressed, and that she was complaining increasingly of pain in her back and legs, as well as demanding more and more medication. Her symptoms worsened over the next day or two, and the staff became concerned over her deepening regression.

It then became apparent in talking with her that she had developed the notion that surgery had permanently weakened her, that she would probably be paralyzed for the rest of her life, and that she would no longer be able to be the self-sufficient, active person she had previously been, but would be forced to live the life of an invalid, dependent on others for help and support. Since her fantasies indicated a beginning shift in her psychological equilibrium, with her underlying dependency needs starting to emerge around the nucleus of symptoms (especially the pain), it was decided to try to activate her as much as was consistent with her postoperative condition. She was reassured that paralysis was not to be expected, and at the same time the physiotherapist was called in to teach her exercises in bed; this was done to focus her attention on physical activity and to enable her to feel that she was actively participating in her recovery rather than merely being the passive recipient in convalescent care.

On the day after the physiotherapist's first visit there was a dramatic change in the

patient. She was cheerful, optimistic about the future, and her pains and other somatic complaints had markedly abated. Asked about her exercises, she enthusiastically replied, "The girl told me to do the exercises four times a day. I've done them seven times already since breakfast—I'm going to get out of here!"

It was apparent that her regression into chronic psychological invalidism had been checked. By picking up the stitches, the widening gap in her defenses of independence and self-sufficiency had been closed, and the dependency needs which had threatened to emerge in full force had been covered over again. The patient's preoperative personality structure had been preserved despite the environmental stresses of hospitalization and illness, which seemed at one point to be overwhelming her life-long patterns of behavior.

It is in situations like this that the nurse can play a crucial part in helping the patient to a healthy recovery. In the first place, she is in a position to observe the early signs of a beginning regression before they may have become apparent to the doctor or before the patient is willing to reveal them to the doctor. As the person who has to look after his wants, the nurse will early discover that the patient is increasing his demands for medication or other services. Furthermore, if the nurse talks briefly with the patient, she may elicit complaints of mounting tension, growing self-concern, depression and increased pain. Her reporting of these observations to the doctor will alert him to the dangers of trouble ahead and will enable him to take measures to prevent the full development of the regressive reaction.

Furthermore, it is not only what the nurse observes but how she behaves with the patients under her care which may be

therapeutic. As with the patients who rebel against submission to therapy, here too the nurse must avoid fostering the dependency needs, even though in this group the invalid seems only too ready to accept, even to demand help and care. It is important that he be expected and urged to do everything for himself, within the limitations of his illness. In this way his personality strengths of self-sufficiency can be maintained to the fullest possible degree, and no more encouragement will be given the underlying dependency than the situation absolutely requires.

Our emphasis has been on the *prevention* of the regressive reaction. There are good reasons for this, for it is often relatively easy to prevent the full development of such a reaction; on the other hand, once it has occurred and persisted for a few weeks or months, the new equilibrium tends to become fixed and, in too many cases, irreversible, so that the patient continues to be markedly incapacitated for a full and useful life by his chronic psychological invalidism.

All of us are familiar with such problems, which occur either during the treatment of physical illness for reasons beyond our medical control or come to us, already fully developed, from other hands. These are the patients we have already described briefly, those who seem helpless to an unnecessary degree, who are often complaining and demanding for the smallest attentions, and who become querulous, irritable and critical when their slightest wants are not filled. Such patients pose a difficult problem in management, partly because of the severity of the emotional difficulties that underlie their behavior, and partly because of the effect they have on the caretaking staff.

All of us tend either to be antagonized by such patients or to feel too sorry for their plight, to become over-protective of them,

and even to rise to their defense against other members of the staff whose attitudes are more critical. Indeed, many patients with this kind of emotional constellation capitalize on these potential differences of opinion, play off one member of the staff against another, and may very effectively disrupt the smooth working of the caretaking team.

In managing such patients it is very important not only that the nurse have knowledge of the nature and structure of the regressive reaction, but that she be aware of the feelings that these patients arouse in her, as in all of us. Only by thus gaining psychological distance on her own reaction will she be able to deal with her own feelings, to the benefit of the patient. This is not meant to imply that she should try to deny such *feelings* within herself, or feel guilty because she has them, but rather that she should control her *actions*, recognizing that the patient's difficult manner and behavior is a product of his disturbed emotional state. In this way, she will be able to avoid being either punitive or overprotective of the patients in her care, and she can provide for them the firmness and consistency of treatment they need.

Finally, it is essential that the nurses and other caretaking personnel dealing with a patient of this sort communicate freely with one another about his management, and, when necessary, have meetings organized specifically to discuss the plan of treatment for him. This can have at least two valuable immediate results. First, it provides mutual support among the nurses and others for dealing with the complaints and demands which the patient makes on them. The opportunity to share and examine together the difficulties each is having diminishes the anxiety which each feels when confronting a difficult patient alone.

Secondly, the chance to tell one another what each is doing diminishes the opportunity the patient has to stir up dissension among the staff by surreptitiously playing one person off against the other. A united staff is much better able to provide a climate of intelligent support around the patient that will put limits on his demanding and will encourage his reaching out to self-sufficiency and a healthy autonomy.

In any consideration of the management of human emotional disorders it is, of course, impossible to anticipate every event-

uality, for each human being is unique, and patterns of behavior—like history—rarely repeat themselves. However, knowledge of the basic principles of human psychology and the main themes underlying emotional disorders provide the nurse with the means for managing each patient as his specific needs dictate. The problem of dependency and its vicissitudes is a central concern for all of us who care for sick people, and, in particular for the nurse who has, after all, the closest and most intense relationship with the hospitalized patient.

Alas! For the moving generation: An essay on residential movement in the United States

*"Alas! For the moving generation of the day, when the tide of advancing backwoodsmen shall have met the surge of the Pacific. They may then set them down and weep for other worlds."*¹

When New England Clergyman Timothy Flint observed his restless countrymen in their compulsive wanderings across the United States during the first two decades of the nineteenth century, he realized, with perhaps prophetic foresight, that the necessity for movement had become an important part of the emerging American character.

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¹ Flint, T., *Recollections of the Last Ten Years* (New York: Alfred A. Knopf, Inc., 1932), p. 197.

² Gordon, A. I., *Jews in Suburbia* (Boston: Beacon Press, 1959), p. 1.

³ Whyte, W. J., Jr., *The Organization Man* (New York: Simon & Schuster, Inc., 1960).

However, knowing the stubbornness of his countrymen, he might have realized that an ocean would not stop a persistent people. In spite of the Pacific Ocean, Americans have managed to gratify their nomadic urge to the fullest up to the present time—and they are showing no signs of stopping.

In 1954, 18.6 per cent of Americans changed their places of residence; by 1955, this number had increased to 20 per cent.² Who are these people? Where are they going? Why are they so restless? And, what are the implications of their wanderings?

Studies have shown that most movers, in proportion to their percentage of the total population, are men between the ages of 25 and 34. These people make up 7.5 per cent of the total population, but account for 12.4 per cent of all movers.³ Women, because they marry at an earlier age than do most men, begin to move in large num-

bers at the ages of 21 and 22.⁴ Another, lower peak of mobility occurs after age 65, and marks entrances into institutions as well as the moving which often follows retirement.

Education as well as age contributes to residential mobility. High school graduates between the ages of 25 and 34 make up 27.3 per cent of all interstate migrants, while people in the same age group, with at least one year of college, account for 45.5 per cent of equivalent movers; it has also been shown that the higher the grades, the greater the likelihood of mobility.⁵ This is not hard to explain; job opportunities for professionals and highly skilled people are scattered all over the country;⁶ or, as in the case of technicians interested in certain aspects of space research, these opportunities are concentrated in one corner of the United States.

As the level of education goes down, mobility tapers off, until we reach those with little or no education, who are extremely mobile,⁷ either because they lack skills for steady jobs, or because they are the victims of mental disturbances which prevent their settling down. The phenomenon of the drifting of schizophrenics has been observed in such large metropolitan areas as Oslo, Norway,⁸ and Chicago.⁹

It is thought that single or divorced male schizophrenics who have left their family settings tend to congregate in the deteriorating centers of large cities. Their constant drifting serves as a protection against emotional involvement with other people.⁸

Type of occupation has a profound influence on movement. We have already seen that both the very skilled and the unskilled are compelled to migrate. The least mobile segment of the population is composed of farm operators, and the self-

employed managers of shops or businesses who are anchored by their property and cannot pick up and move without great difficulty. White-collar workers and factory hands have become stable since trade unions, protected by government, have been able to guarantee their welfare and job security, and since better wages have enabled them to acquire property.⁹

As salaries increase above \$5,000 per year, mobility also rises, and the trend is increasing. In 1953, 14.8 per cent of *Fortune's* subscribers changed their address; in 1954, 16.6 per cent moved; and in 1955, the number had increased to 17.4 per cent.³

Three-fourths of all movers are members of large organizations, such as government, the military, and big corporations. General Electric compared a cross-section of 45-year-old executives with a group aged 35. It was found that 42 per cent of the first group had moved at least once between the ages of 25 and 35, while in the younger group, 58 per cent had moved.

⁴ Duhl, L. J., presiding at Conference on the Problems of the Migration Among the American Middle Classes (Bethesda, Md.: National Institute of Mental Health, December, 1960). Unpublished, mimeographed report.

⁵ Duhl, *op. cit.*, p. 8.

⁶ Leighton, A. M., J. A. Clausen and R. N. Wilson, *Explorations in Social Psychiatry* (New York: Basic Books, Inc., 1958). Also, Ødegård, Ørnulv, "The Distribution of Mental Diseases in Norway: A Contribution to the Ecology of Mental Disorder," *Acta Psychiatrica et Neurologica*, 20(September, 1945), 43.

⁷ Leighton, Clausen, Wilson, *op. cit.* Also: Faris, and Dumham, *Mental Disorders in Urban Areas* (Chicago: University of Chicago Press, 1959).

⁸ Leighton, Clausen and Wilson, *Ibid.* Also: Gerard, D. L. and L. Huston, "Family Setting and the Social Ecology of Schizophrenia," *Psychiatric Quarterly*, 22(January, 1953), 317.

⁹ Duhl, *op. cit.*, 87.

This constant shifting of personnel is caused by the increased decentralization and expansion of most big firms, and not necessarily by planned policy.

However, it is felt that a good executive should be a well-rounded individual who has seen and experienced at first-hand all the facets of his company. Any objections to the moves, as voiced by the employee, are taken as signs of unwillingness to serve the corporation and are chalked up against him.⁸

Modern Americans move not only because of their jobs or their education, but also to escape the minority groups which are migrating to the major cities.¹⁰ Between 1950 and 1957, the number of non-whites in the five boroughs of New York City increased by 320,221, or 41.3 per cent; while the white population decreased by 416,707 or 51.9 per cent. During that same period, the white population of Nassau County, N. Y., increased by 75.2 per cent.¹⁰ The former majority group is then followed into the suburbs by the richer members of the minority who are afraid of being isolated in ghettos; and the process of escape and replacement continues.

The Bureau of Census estimates that the number of families increased from 43 million in 1956 to about 51 million in 1960; the Bureau also estimates that the number will rise to 54.5 million by 1975.¹⁰ As the population increases and cities become overcrowded and choked with traffic, a shortage of possible building sites develops. Tearing down old houses involves the problems of relocation. People are thus

forced to move by the sheer pressure of their fellow men.

It is necessary to point out that, for whatever reason Americans move, it is easier for them to do so than it is for the citizens of many other countries. This is not to say that Americans do not face serious problems when they uproot themselves from their home towns and cities, but rather that because of their history, they have precedents and sanctions which are not possessed by other, more sedentary peoples. Americans accept movement as a natural and unquestioned part of their culture.¹¹

When the first settlers came to this country, they had broken ties with the past as few people had done before. They had settled in an alien wilderness, 3,000 miles from their former homes; moreover, they had come from England, a country which, in the sixteenth and seventeenth centuries, offered chances of socioeconomic and therefore of spatial mobility to a greater extent than did most other European lands.⁹ The first settlers, then, might have been expected to be highly mobile, but until the nineteenth century, this, for the most part, was not the case.

The colonists were first checked by geography. They were compelled to remain near the coast and on the shores of rivers since there were, at first, few roads other than Indian trails. When, in 1635, Thomas Hooker moved from Plymouth to Connecticut with a small party of settlers, the trip of 100 miles took 2 weeks.¹²

The absence of feudal obligations in the New World made movement easier by eliminating the binding sets of reciprocal obligations which chained the European peasants to the soil. However, in the early years, the settlers discovered an almost equally effective way of preserving group unity—planned expansion.¹³

¹⁰ Gordon, *op. cit.*, p. 9.

¹¹ Mead, M., *And Keep Your Powder Dry* (New York: William Morrow & Co., Inc., 1942).

¹² Dunbar, G., *A History of Travel in America* (New York: Charles Scribner's Sons, 1937).

Those wishing to start a new township obtained permission from the General Court to settle six square miles of land adjoining an already civilized area. The settlers then laid out a main street and a village green; they set aside plots for a church and a school. The remaining land was divided into town lots and fields. This system preserved the cultural and religious life of the people, and offered a measure of security from the Dutch, French, and Indians. This worked well while the population was small, while franchise depended on church membership, and while the first settlers, like every first generation of immigrants which was to follow, huddled near the coast and tried to preserve their native customs.

By the 1750's trappers, followed by settlers, had spread inland from Canada, Mexico, and the English colonies. Roads were built, and in 1806, Lewis and Clark pushed through to the Pacific. The great trek West had started. By 1812, more than one million people were living in the West.¹³ They suffered from forest fever, malaria, milk sickness, and swamp-bred ague. They died in wretched poverty, far from their friends and relatives, and they were massacred by Indians. By the 1840's, expansion, or "manifest destiny," had become a kind of religion in America. It was felt that the nation was fated to occupy the whole continent.

Why had the American people turned into a nation of wanderers? Was it, as Jefferson said, because they found it "... cheaper to clear a new acre than to manure an old one"?¹⁴ This was part of the answer, but by no means all of it. Many traveled to find "elbow room" in a country where foreign immigration and large plantations had occupied most of the coastal area. Traveling had become much easier since the invention of the river boat. By

the 1850's, better revolvers and rifles made self-defense easier.

The extension of the power and influence of the United States government into the West, with its courts, garrisons, and land offices, encouraged many to leave the security of the crowded East Coast for the western land, which was rapidly gaining in value; and with the passage of the North West Ordinance, schools and colleges could be built. But above all, the people were led West by the power of their own imaginations. "I am ready to believe," wrote Timothy Flint, "from my own experience, and from what I have seen in the case of others, that this influence of the imagination was no inconsiderable agency in producing emigration. . . ." ¹⁴

The poverty-stricken immigrant from Poland, Ireland, or Bohemia set out for the unbelievably rich farmland of the Middle West where, for very little money and a great deal of credit, he could own as much land as the richest farmer in his native country. He planted his fields and orchards, built a house and barn, and heard that further west, land was even richer. He sold his holdings to the latest arrival and moved on.

This frenzied movement was by no means confined to the frontier. This was the time when everyone in New York City changed his house every May first. Travelers reported a grand game of musical chairs, with the streets cluttered with carts and wagons full of household goods, and people all bumping into each other and blocking traffic.⁹

By the end of the nineteenth century,

¹³ Hofstadter, Richard, William Miller and Daniel Aaron, *The United States: The History of a Republic* (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1960).

¹⁴ Flint, *op. cit.*, p. 234.

the industrial revolution arrived and reduced the wanderings of people. Society became far more rigidly stratified than it had been at the beginning of the century. The upper and middle classes settled in the towns, held down by their property and their emerging position in society. Only the lower classes could not find a haven. Caught without property by the revolution, they became a feared element in society. Newspapers commented on the tramp problem, the "dangerous classes."⁹

During the last part of the nineteenth and the early part of the twentieth centuries, the typical American small town, with Main Street and white picket fences, became the norm in most parts of the country. Then, during World War I, the hectic movement began again.

The 1920's brought a series of spectacular land booms, followed by equally spectacular collapses. During World War I farm prices had risen sharply. People rushed to buy land, not realizing that with peace the prices would fall again. In 1920, farm prices totaled \$8,368,000,000; by 1932 they had fallen to \$2,285,000,000.¹⁰ This drop in prices, as well as the increasing use of new farm machinery, caused a mass migration from the farms to the cities. In 1920, for the first time in American history, more than half the population lived away from the land. But before long, the people began to rebel against the noise and dirt and bustle of the cities. In 1925, the Florida land boom appeared.

"Go to Florida—where enterprise is enthroned—where you sit and watch at twilight the fronds of the graceful palm, latticed against the fading gold of the sun-kissed sky—where sun, moon, and stars, at eventide, stage a welcome constituting the glorious galaxy of the firmament. . . ." So wrote the vice-president of a Miami bank.¹⁵

In 1920, Miami had a population of 30,000. By the beginning of 1925 it had risen to 75,000; in the next few months, 150,000 people were packed into the city.¹⁶ When hurricanes and bank failures hit Florida between 1926 and 1929, they ended one boom but they could not prevent others.

In the 1930's, contrary to many reports, people were unusually stationary. Population reduction in many parts of the country was due to the lack of replacements, for people were too poor to move.¹⁷

During World War II, little building was done for the civilian population. But with the end of hostilities, and the passage of various G.I. bills, suburbia began to grow. By 1959, more than 47 million people lived in the suburbs; 12 million of these moved to suburbia in the decade following 1948. The Bureau of Census estimates that by 1975, more than 88 million people will be living in the suburbs.¹⁸ It seems evident that Americans not only are still moving; they are also going to move in the future in ever-increasing numbers. What are some of the results of this residential mobility?

A great deal has been written, much of it highly sensational, on the mentally unhealthy consequences of moving, especially to suburbia. There appears to be little valid evidence to support these negative opinions. Certainly, movement causes many painful problems, but these same problems have been present since the be-

⁹ Allen, F. L., *Only Yesterday* (New York: Bantam Books, Inc., 1959), p. 191.

¹⁰ Allen, *op. cit.*, 191.

¹¹ Malin, J. C., *The Grassland of North America* (Ann Arbor, Mich.: University of Michigan Press, 1947).

¹² Gordon, *op. cit.* p. 251. Also, *U. S. News and World Report* 16(August 10, 1956).

ginning of the nation. People adjusted in the past to their changing environments, and there is no reason why the present generation cannot resolve its difficulties as well as did its predecessors. Discomfort, which is an inevitable consequence of change, does not necessarily lead to mental deterioration; it may, and often does, act as a stimulus to growth.

An obvious consequence of movement is the leaving of familiar people and places, or the tearing-up of roots. In a familiar setting a person can find his own identity by comparing himself with an environment which does not change, or which changes in a predictable way. In fitting into a community, he learns how to act appropriately on different occasions, and he receives gratification of his interpersonal needs. He is bound to the people around him by a common culture, by a sense of exclusiveness which comes from the geographical limitations of the community, and by their common problems and aspirations. When all these ties are broken, and a person moves into a community which has its own set of values and associations, an identity crisis takes place. When a familiar situation brings unfamiliar reactions and responses, the individual becomes confused, anxious, and depressed. He is unable to act effectively, and he has difficulty keeping his emotions under normal control.

It is estimated that it takes from four to five years to settle down completely after a move.¹⁹ One of the first difficulties encountered is the adjustment to new physical surroundings. Like animals, people are more comfortable in familiar places. A house filled with memories and associations, where one feels a sense of belonging, which is, in fact, "home," is hard to replace quickly. The leaving of significant space is perhaps hardest for those who

move involuntarily. Some of the former residents of the West End in Boston who had been displaced by an urban development program, for instance, went back frequently to the sites of their old homes to stare at the rubble and to talk among themselves.²⁰

Timothy Flint expressed the alien feelings of a mover when he said, "... the immigrant experiences not only the gloom of seeing himself among strangers, to himself, to his country, to his opinions, and habits, but he is even in the midst of a nature that looks upon him as an intruder."²⁰

More serious than the lack of familiar settings is the lack of familiar people. This is much easier for men and career women to bear than it is for housewives, who are separated from relatives and former neighbors without the distraction and compensation of a job. To them falls the burden of creating a network of friends in a new community. Unlike their husbands, who have a great deal in common with their new colleagues, wives may have a hard time making friends. Not knowing the customs of their new surroundings, they are not sure whether to invite a neighbor over or to wait for an invitation. A nineteenth-century settler in Iowa reported that one neighbor waited three years before paying a visit.²¹ This process of making friends is not made easier by the aloofness of the natives of many small towns who are being overwhelmed by crowds of invading newcomers. These towns often become battlegrounds for leadership between the old and new inhabitants.²

¹⁹ Fried, M., Personal communication, 1960.

²⁰ Flint, *op. cit.*, p. 235.

²¹ Commager, Henry Steele and Allan Nevins, *The Heritage of America* (Boston: Little Brown & Co., 1948). Also: Brown, H. C., *Grandmother Brown's Hundred Years*. (Boston: Little Brown & Co., 1929).

Making new friends may seem a futile task to those who have moved too often and broken too many ties. Timothy Flint complained bitterly of this. "One of the most unpleasant circumstances attending the life which I lead is that we naturally form intimacies, which are extremely painful in the breaking. . . . I have so long and so often experienced the anguish of breaking off these ties, which, however pleasant, are so transient and frail, that I have ended by finding gloomy thoughts connected with every effort to form a new acquaintance. . . ." ²²

Most modern movers, however, are not as fatalistic as Flint. They are able to make shallow friendships which allow for a normal social life, while preventing too much unhappiness during moves.²³ Here is a case where, at least on the surface, the moving generations have developed some protective mutations; but under this surface is a strain of loneliness which has been discovered by Madison Avenue. Just as in the 1920's, the theme of advertisements was a return to nature; today the theme of *friendship* sells houses.

"You belong in Park Forest! The moment you come to our town you know you're welcome. You're part of a big group, you can live in a friendly small town instead of a lonely big city. You can have friends who want you—and you can enjoy being with them. Come out. Find out about the spirit of Park Forest." ²³

Another result of mass movement is the bringing together in a single town of people of many different backgrounds and cultures. Although this is not as acute a problem as it was in the days of the westward mi-

gration when different nationality groups lived, and frequently clashed, in one small area, it still causes problems. Francis Parkman ²⁴ and Flint both record the hatred and suspicion the pioneers felt toward conniving Yankees or militant Mormons; but when these people were forced to live together, they overcame many of their prejudices and acquired a broader view of the world. This is also true today, where the larger result of heterogeneous communities is a more universal culture.

It has been fashionable for some time to decry the so-called menace of conformity which seems to flourish in the suburbs. Conformity, however, is the essence of culture, and consists of acting, or dressing, or speaking as do all other members of a group. This is so obvious that it hardly seems worthy of mention; and this is the significant point. In an old, established culture, conformity is unconscious and accepted. It is a method of freeing people's minds from puzzling over every minor act of their daily lives so that they can concentrate on something more important. It is also a means of identifying with a group.

When Americans move into a new, heterogeneous community, they look about them in search of local culture to which they can adapt themselves. But since there are as yet no established customs, everyone else is doing the same thing. New fads spring up overnight, and they are embraced by all with great relief. Conformity in modern suburbs is obvious only because it is so self-conscious and forced. Eventually it will probably settle down into a new subculture, and then the people will be able to think of something besides the color of their draperies or the relative age of a robot lawn mower.

Rigid conformity is most apparent in very quickly developing towns. It often causes anguish to the uninitiated as W. H.

²² Flint, *op. cit.*, pp. 78, 79.

²³ Whyte, *op. cit.*, p. 284.

²⁴ Parkman, F., *The Oregon Trail* (New York: Mentor Books, 1955).

Whyte, Jr. discovered from one of his interviews:

"Estelle is a case. She was dying to get in with the gang when she moved in. One day she decided to win over everybody by giving an afternoon party for the gals. Poor thing; she did it all wrong. The girls turned up in their bathing suits and slacks, as usual, and here she had little doilies and silver and everything spread around. Ever since its been almost like a planned campaign to keep her out of things. Even her two-year-old daughter gets kept out of the kids' parties."²⁵

All aspects of moving are hard for children. As one mother put it: "The kids look forward to moving, and yet they dread it. They hear that if they move to a house they can have a little dog or cat. They like that. But their friends—they hate to leave their friends. My little daughter got worried over this and I had to reassure her we are going to stick around for a while. . . ." ²⁶ Ironically, children are the most common reason given for moving to the suburbs. It is felt that once away from the danger of traffic and the bustle of city life, in a rural atmosphere with plenty of gardens and good schools, childrearing will become miraculously easier. This is not always the case. Often, children arrive in a new school only to find the friendship groups already tightly formed. They may be unsuccessful in their first attempts to break down these barriers. In extreme cases they may retire from the struggle and become withdrawn; some may even make half-hearted suicide gestures in a bid for sympathy. Occasionally girls get into sex trouble in an effort to at least attract some boy friends.²⁷

Most suburban delinquents, however, do not evolve in so spectacular a manner. A child-oriented culture keeps them in a dependent status for a longer period than

used to be the case. This exaggerates conflicts with parental authority. They become bored when their abilities are not adequately challenged in work situations, since in many suburbs appropriate work is not readily available for young people and, having no healthy outlet for their energies, they turn in on their own peer groups.

Today, many adolescents in the suburbs see no alternative to aimless hanging around the corner drug store. In the communities of their origin, they might be governed by a strict code, but when their parents move to other surroundings, the family does not feel secure enough to enforce the old rules. Since new codes are seldom provided, both parents and children are confused, and the results are often unfortunate.

This problem, like the others, is not exclusively contemporary. Timothy Flint noticed it among the rich families of the South more than 100 years ago.

"I felt grieved to see so many fine young men exempted from labour . . . and falling, almost of course, into the prevailing vices of the West—gambling and intemperance."²⁸

"There is a loud call for the stern exercise of parental monitors and authority—a more alarming prospect cannot be opened to a country than to have a great many active, intelligent, and high-spirited young men, without object or pursuit, let loose with all their passions, and all their ambition, to prey upon society. Villages are but too much filled with idle and dissipated young men."²⁹

²⁵ Whyte, *op. cit.*, p. 359.

²⁶ Whyte, *op. cit.*, p. 289.

²⁷ Gordon, R. E., K. K. Gordon and M. Gunther, *The Split-Level Trap* (New York: Dell Publishing Co., Inc., 1960).

²⁸ Flint, *op. cit.*, p. 62.

²⁹ Flint, *op. cit.*, p. 71.

It is claimed by many messengers of doom, such as Gordon, Gordon, and Gunther in *The Split-Level Trap*, that residential mobility destroys mental and physical health.²⁷ I have found no reliable evidence to support this assumption. Certainly many people today suffer from ulcers and high blood pressure,²⁷ but these may be the product of a highly competitive life, in which movement is a symptom not a cause. Many more movers than sedentary people are said to suffer from mental disorders.²⁷ Some who become ill may do so as a form of surrender when the move does not solve all the problems it was meant to. And mental illness may cause habitual mobility rather than being its result.

An early study, which casts some doubt on the fatalistic views of a sizeable body of authors, is that of Tietz, Lemkau, and Cooper, conducted in Baltimore in 1936.³⁰ This report shows that there is a possibility that personality disorders of various kinds cause mobility, rather than being results of it. The authors compare the rates of disorders among various ethnic and income groups in Baltimore according to the length of residence in the city and in their present homes. The inhabitants are also compared with a group of people who have just moved into the city from the outside. It was discovered that the habitual movers had the highest rate of disorders, even higher than those who had just come into Baltimore.

The findings of this study must be inter-

preted with caution. It is possible, for instance, that those moving into the city suffered as much as did the native movers; but, because they were unfamiliar with the local care-giving agencies, they did not appear on the public health records until they counted as natives. Another possible loophole is the fact that the figures used for the study were taken from a variety of agencies, some of which had very full records, while others did not.

The lives of movers are said to be culturally sterile. Flint remarked on the unfortunate prevalence of novels on the frontier and the lack of any improving literature. The churches could not be much help in bringing culture to the frontier, since, apart from the Catholic immigrants, the settlers cared very little for organized religion. It was not said for nothing that "... when we cross the Mississippi we travel beyond the Sabbath."³¹ Religions broke into dozens of sects in an effort to involve the elusive people who were revolting against the restraints of a perhaps too-doctrinaire past.

Today in suburbia, many people join religious groups for the sake of their children's Sunday School education, and for the minister's counseling.³ Often ignoring denominational boundaries, they pick their churches by geography. These places of worship then become cultural centers where friends meet. In Wellesley, Mass., where there is a turnover of about 1,600 a year out of a total population of about 21,000,³² at least half of the 144 clubs are connected with churches. This use of religious institutions to fulfill social needs has been recognized by some of the churches themselves.

"Lots of acquaintances—not many friends. Is this increasingly true of you? Look at your life. You may find that it lacks those spiritual experiences which

³⁰ Tietze, C., P. Lemkau and M. Cooper, "Personality Disorders and Spatial Mobility," *American Journal of Sociology*, 48(July, 1942), 29.

³¹ Flint, *op. cit.*, p. 174.

³² Mayo, C., *Community Organizations* (Wellesley, Mass.: Wellesley Human Relations Service, 1951). Unpublished typed report.

bring people together in understanding and friendship."

"Participation in the activities of the neighborhood church supplies the spiritual force to weld lasting friendships. Meet future friends in church next Sunday."

"A cordial welcome awaits you at your neighborhood Episcopal Church."³³

Thus, movement may not necessarily be a bad thing. Is it then a good one? Movement has many advantages, not the least of which is an offer of escape from intolerable circumstances. This may mean relief from a too-rigid social structure; it may mean escape from gossip, prejudice, or interfering relatives. Moving from an apartment to a house may provide privacy and extra room. Members of a family no longer get into each other's way; and, if they do, they can protest without fear of disturbing the neighbors. Immigrants to Tremeealeau County, Wis., at the end of the nineteenth century reported that they felt that their move had promoted self-confidence, optimism, resourcefulness, perseverance, neighborly co-operation, a sense of responsibility, and initiative.³⁴ Certainly, any modern mover with a garden would agree with the last point.

Another advantage of moving, especially to a growing suburb, is the opportunity of becoming a "big fish in a small pond." Clubs, and organizations often demand and get a high degree of participation.³⁵ Members receive a great deal of experience in organizing groups of people, and this they may find helpful in their daily work.³ People who never would have dreamed of asserting themselves before, suddenly blossom into chairmen and committee women. Flint saw this phenomenon in the early West:

"The people in the western country, for some cause, are far more eager for distinc-

tion and for office than at the eastward. Many who would never have aspired to an office in the region from which they come, have found themselves thrown into positions where this new hope of distinction was awakened."³⁶

The people of Flint's generation, in spite of unbelievable hardships, helped to establish the United States. In the face of nature, Indians, and a shortage of trained doctors, nurses, teachers, and clergymen, they not only survived; they kept moving.

Today's movers have, in many ways, profited by the experience of their precursors. People are no longer as eager to fight among themselves as were the pioneers; they put far more effort into getting along and understanding each other. They have found ways of protecting themselves against the pain of continually separating from friends and communities; and they have managed to adapt such care-giving agencies as the church to fulfill not only spiritual but also social needs.

In this paper we have discussed some of the factors which have made residential movement an acceptable part of the American culture. We have seen its origins and its history from the first settlers to the present age of suburbanites. The reasons for its being have ranged from a search for land, to the edicts of big business; from a desire for elbow room, to the wish to escape minorities.

In spite of the fact that a great deal has been said and written on residential movement and its unhealthy results, there

³³ Whyte, *op. cit.*, p. 378.

³⁴ Curtis, *The Making of an American Community* (Palo Alto, Calif.: Stanford University Press, 1959).

³⁵ Gordon, *op. cit.*, p. 203.

³⁶ Flint, *op. cit.*, p. 207.

is very little scientifically validated knowledge about its long-term effects on mental health. It has been evident for years that movement is, in many ways, a painful experience; but it remains for future studies to decide if it is more than that. One is tempted to say that if generations of intrepid pioneers could willingly spend their lives in the midst of constant change, the ill-effects of their Odyssey must have been minimal. However, the observers of their ways of living, although untrained

in psychology, recorded enough misery in the life of the frontiersman to cast some doubt on this opinion.

The possible bad effects of movement then, should not be denied, but in the absence of adequate scientific study they should not be exaggerated. Meanwhile, the good effects of change and challenge must be remembered. In the successful surmounting of stress, man gains strength for more difficult and more rewarding tasks.

The homosexual's image of himself

The Daughters of Bilitis, an organization composed mainly of female homosexuals, surveyed the habits and history of 157 female and 100 male homosexuals through a questionnaire.

The results of the female questionnaires were summarized in the September, 1959, issue of their journal *The Ladder*;¹ and the female and male questionnaires were compared in the September, 1960, issue.² A year later, further details were made available by the Daughters of Bilitis. These data, correlated with additional clinical material obtained by the author, provide an opportunity to look at certain aspects of the homosexual's image of himself.

The questionnaire was circulated through the San Francisco members of the Daughters of Bilitis and through the Mattachine Society, an organization devoted to the interests of male homosexuals. Through 104 questions it covered the his-

tory and present status of the respondents' sexual behavior; their feelings of psycho-

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The major portion of the material for this paper was collected while the author was associated with Langley Porter; the remainder, while he was on the staff of the U. S. Naval Hospital.

The opinions or assertions expressed in this paper are the private impressions of the author and are not to be construed as official, or as reflecting the views of the Medical Department of the U. S. Navy, or of the naval service at large.

¹ "D.O.B. Questionnaire Reveals Some Facts About Lesbians," *The Ladder*, 3(September, 1959), 4-26.

² "Some Comparisons Between Male and Female Homosexuals," *The Ladder*, 4(September, 1960), 4-25.

sexual identification; their family, childhood, and adolescent history; and their history of social adjustment, including jobs, income, movement, psychotherapy, education, and social habits. The respondents were from the segment of the homosexual population who are relatively more accepting of their homosexuality.

This informal survey did not allow for controls and consisted of manifest content, without an attempt to obtain information about unconscious or censored material. Some data, however, are pertinent to the appraisal of conscious attitudes and self-images, and are summarized below.

RESULTS

The average number of brief homosexual contacts was greater for men than for women. Most men and women had fewer than five brief contacts: the median male reported five; the median female, three. The most active female, however, reported hundreds of short contacts, and the most active male estimated a figure of 5,000. The average duration of the respondent's present homosexual relationship was 4.6 years for females and 5 years in males; however, half of the men stated they were currently involved in more than one homosexual relationship.

The women's first homosexual experience usually came after their first heterosexual experience, a sequence suggesting that they may turn to women after disappointment with men. The men's first sexual experience was likely to be homosexual. Men expressed awareness of homosexual tendencies earlier: the average age of earliest awareness was 14.7 years in men and 16.6 years in women.

Several interesting differences were noted in their expression of uncertainty on questions concerning the number of homosexual relationships; female homosexuals were sometimes uncertain whether to count emotional relations that did not involve organ contact, whereas male homosexuals had trouble deciding whether to count—and generally did not count—organ contacts that were not part of an emotional or love relationship. This suggests that women regard affectionate feelings for other women as less deviant than sexual acts, whereas men regard sexual acts as less deviant than a male-male tenderness.

Current American culture does not clearly separate sexual roles, and modern women exert pressure on men to adopt some characteristics that are stereotypically female.³ Nevertheless, the male seems to be the preferred sex. This attitude may be changing with the return of respect and esteem for motherhood, and probably was truer during the childhood of the respondents than is now the case. The feminine role and identification was least predominant in both male and female homosexuals.

A few figures illustrate these trends. Of the men, 30 per cent felt the masculine role predominant within themselves, as compared with 38 per cent of the women; 6 per cent of men and 20 per cent of women listed feminine as the predominant role; while 57 per cent of the men and 36 per cent of the women considered their role variable. About 7 per cent did not answer the question.

In the women, there were age differences: 25 per cent of those over age 32 expressed no identification; 48 per cent said they had a male identification; and 21 per cent mentioned a female identification. Of those women under age 32, 43 per cent had no choice of identification; 31 per cent

³ McKee, J. P., and A. C. Sherriffs, "Men's and Women's Beliefs, Ideals, and Self Concepts," *American Journal of Sociology*, 64 (January, 1959), 355-63.

indicated masculine; and 21 per cent female identifications.

The strong element of choice in responses made to this type of questionnaire suggests that these data represent an emotional or defensive preference for masculine identification. Certainly the tomboy is more acceptable to society than is the sissy. Genetically, these preferences may be determined by frustration of oral dependency needs, as stated by Bergler: ⁴ the person is so angry with the disappointing breast and breast-substitute that he discards the whole disappointing sex — women. Masculine strivings may be used as a defense against oral-dependency wishes, which are regarded as a feminine trait.

In the responses of the 157 female homosexuals, the 56 who were not exclusively homosexual were less likely to identify with masculinity than the 101 who were exclusively homosexual. Half of 16 exclusively homosexual women who felt a female identification remembered their adolescence as unhappy, compared with a quarter of the 46 exclusively homosexual who felt a masculine identification.

Those who made some identification as either masculine or feminine were more likely to report a happy adolescence than those who did not so identify themselves. This would agree with the ideas of Erikson ⁵ that adolescent trauma and stress may precipitate a sexual-identity diffusion that intensifies adolescent disturbances.

Of the females who were exclusively homosexual and felt neither masculine nor feminine, 38 per cent had sought psychotherapy. The interpretation of these data is difficult because of the variations in individual awareness, responsiveness and background. No comparisons are made to nonhomosexuals' sexual identification. Nevertheless, a few psychoanalytic studies of adolescence substantiate the feeling that

it is better to have an identity, even a counteridentity, than to suffer from identity diffusion.^{6, 7}

The statement of usually unspoken and informal attitudes provides a baseline for examination of the changes in these attitudes. Many in our American society have the attitude: "All homosexuals are bad." Those who have professional contacts with homosexuals often have the attitude that there are good homosexuals and bad homosexuals. The idea of the good homosexual suggests a person who conforms outwardly to the modes and mores of society and is able to form lasting and satisfying relationships. The image of the bad homosexual may include homosexual promiscuity, aggressive homosexual displays, numerous short relationships, alcoholism, sociopathic behavior, and the courting of conquests or the seduction of relatively nonhomosexual individuals.

These questionnaires suggest some changes in the subgroups of female homosexuals. Of the 77 female homosexuals under age 32, 17 per cent had been arrested, but only 6 per cent of the 77 over 32 had been arrested. The younger group also indicated that their homosexuality was more conspicuous to fellow workers, that they were more likely to frequent predominantly homosexual bars, and that they were less certain of their psychosexual identification.

⁴ Bergler, A. M., "Homosexuality and the Kinsey Reports," in *The Homosexuals* (New York: Citadel Press, 1954).

⁵ Erikson, E. H., "Identity and the Life Cycle," *Psychological Issues* (New York: International Universities Press, Inc., 1959), Vol. 1, No. 1.

⁶ *Ibid.*

⁷ Pearson, Gerald, *Adolescence and the Conflict of Generations* (New York: W. W. Norton & Co., Inc., 1958).

Society is increasingly aware of homosexuality and is becoming more tolerant of the so-called "good" homosexuals. Homosexuals are allowed to be more open in their behavior. The movie censorship code has officially allowed the depiction of sexual deviations to catch up with existing movie practices that depicted only nuances of deviations. This growing awareness of homosexuality has, I think, fostered some new uses of homosexuality as a mechanism of defense in adolescents and young adults.

A subgroup of younger homosexual women seems to use homosexuality not so much as a necessary outlet for variant sexual impulses as a form of antisocial acting out much as adolescents will prefer a counter-identity, such as gangster or tough guy, to the null or weak identity that to them may be the only alternative. Perhaps the meagerness of adequate models of womanhood in our society is one cause of this. Our present culture has few heroines; young girls have little to emulate in the typical movie or television female lead—a childlike, characterless, sexy figure.

In the following case, a girl used homosexuality as an antisocial, antiparental form of acting out. Her choice was related to her psychosexual development.

A woman in her mid-twenties came for psychotherapy because of nervousness following voluntary withdrawal from narcotics. She was from a prim, middle-class, Jewish family. Her mother, the dominant member of the family, constantly teased the patient and her father. The patient resented her mother's bickering and called herself "Daddy's girl" because the father protected her from the mother's teasing. The father was timid in all contacts with adults, "as if he only knew how to get along with little kids." Although studiously tolerant, he wished to move because the neighborhood contained too many Negroes. She felt akin to him because she, too, had few friends.

She was a behavior problem at home and at school. Puberty, especially her menarche, was

a shock to her. The relationship with her father changed when he reproved her for dating and moralized about her attire and make-up. She felt deep resentment toward him; her feelings of tension increased around the house, and she would occasionally break things. She ran away at age 17.

Soon after she ran away, she married a boy who had been in reform school several times. Together they committed petty thefts and used narcotics. She left him and went to another city where she had several short affairs with men, and one long and several short homosexual relationships. She continued to use narcotics and to mingle with the petty criminal, antisocial fringe. Her most satisfying emotional and sexual experience was with a Negro man, who was protective of her. After his arrest, she returned home, voluntarily entered a hospital for narcotic withdrawal, and then sought psychotherapy.

These actions represented giving up a counter-identity that she had desperately resorted to during a crisis in her identity conflict. There was the characteristic bisexuality of such conflicts, and a longing for a mother. Because of self-contempt and an intense fear of rejection, she sought nurture from people she felt would not reject her, and she offered sexuality in return. There was the secondary gain of punishing her parents by acting in ways hateful to them.

Of interest is the male adolescent with conflicts of sexual identity who leaves home in search of nurture, and who may enter into symbiotic union with an older male who, too old for the usual casual relationships, offers a fathering role in return for sexual companionship. These relationships may be therapeutic emotional experiences in the resolution of dependency conflicts, but they may fixate homosexuality as the preferred means of sexual gratification.

The increased public awareness of homosexuality has led to greater anxiety in non-homosexuals about latent homosexual impulses. It has also led to a defense against this anxiety and the impulses, a variation of reaction-formation which might be termed "showing the homosexuals." Male adolescents, almost invariably in a group, search for homosexuals whom they abuse

and beat so as to demonstrate their contempt and masculinity. Repressed rage from the presumed rejection of parents and society may be mobilized and vented on the victim. An example follows:

One summer evening four teen-age boys drove around with the object of "finding a homosexual to scare." At a lonely streetcar stop they asked a 27-year-old male teacher, "Are you queer?" The teacher said, "How would you answer that if I asked you?" and handed them his wallet. One of the youths, angered at the remark, pushed him. The boys became violent and one of them later admitted to stomping on the teacher's head while he lay on the ground. They left him lying on the tracks, where a streetcar killed him.^{8, 9}

The feared trait was projected and then further defended against by reaction-formation. The threatened exposure of the projection triggered a violent response. I have not heard of any cases where women were similarly accosted.

Homosexuality itself can be used as a defense. Individuals perplexed by the social disarticulation, uncensored sexual material, and diffusion of identity characteristic of certain schizophrenic processes may regard themselves as, or behave as homosexuals in order to bind anxiety to a specific source. Late adolescent males in the setting of an acute, closed, psychiatric ward often challenge each other's sense of identity by pretending to be homosexuals, by making mock homosexual advances, or by accusing others of being homosexual.

On deeper inquiry, such individuals do not have homosexual wishes but, rather, a diffusion in their sense of masculinity. To them, the opposite of the lost sense of male

sexual identity is homosexuality. Pressed by feelings of anxiety, depersonalization and confusion, they flee to homosexual role-playing to regain the feeling of being a person. As their original sense of identity reintegrates, the defensive homosexuality is dropped.

SUMMARY

Homosexuality refers not only to sexual practices but to a kind of self-image. An individual may have a variety of self-images that change with different social situations or different ego states. Some individuals change fluidly and some maintain more fixed self-images. Self-image is closely related to social roles. As the ideas society has about homosexuality change, the homosexual's image of himself changes. Society is both more aware, and relatively more accepting of the phenomenon of homosexuality.

Data from a survey of overt homosexuals support the idea that they feel freer in their behavior and somewhat less conflicted in the acceptance of a homosexual self-image. Latent homosexuality, however, is more likely to emerge in conflicted individuals. The greater availability of a homosexual role may encourage individuals with sexual identity conflicts to try it out or, as in the male adolescents cited, to repudiate it violently.

⁸ *San Francisco News-Call Bulletin*, September 9, 1961, pp. 1-2.

⁹ *San Francisco Examiner*, September 9, 1961, pp. 1, 6.

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Identity and ethnocentrism in American Negro college students

This paper reports one of several studies of the sociocultural determinants of human behavior, with particular reference to problems of identity and social role. The groups under investigation all come from the Negro¹ population of urban Balti-

more, a border city in a state of social and ecological transition.

One extreme example of an impaired sense of identity is the schizophrenic who has no feeling of relatedness to the human group in general and great difficulty in reconciling his several, often incompatible, images of himself. For this reason, our studies in the area of identity began with the schizophrenic.

An earlier paper concerned with young Negro male schizophrenics made the point that "many, if not all, American Negroes appear to suffer from a series of problems in identification, stemming from culture conflict, caste restrictions and minority status, mediated in part through the family structure (3)."

THEORETICAL POSITION

While the present study is concerned with young Negroes of ages comparable to those

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¹ The term Negro as used in this paper is primarily a social rather than an anthropological definition. Negro means all those individuals: (1) who define themselves as being Negro; or (2) whom the Negro social world defines as being Negro; or (3) whom the white social world defines as being Negro; or (4) any combination of these.

of the schizophrenic population, these college students differ significantly from the patients. They are upwardly mobile, outstripping their parents in economic and educational status, conscious of their human rights and what has been denied them. They are in the process of forging new identities for themselves as Americans, as Negroes and as potential leaders of the least assimilated minority group in this country.

Our consideration of these students involves several general propositions derived from observations of the United States society; the validity of these propositions, therefore, may vary from one culture or society to another:

(1) A "sense of identity" is a function of the nature of one's relationships to others. It develops, first, from membership in a dyadic system, including the infant and mothering person. This is extended to membership in a family system and later to membership in other human groups. These groups provide a context which make one's behavior socially meaningful (7). Differential social relationships learned through group interaction are a result of a social structure, including the caste and class systems as functional ingredients (5).

(2) One tends to interact with individuals who are members of groups with (a) similar physiognomic characteristics; (b) a shared communicative network; and (c) shared socially significant symbols.

(3) These interactional choices may be viewed in functional terms insofar as they: (a) serve anxiety-reducing and need-gratifying functions for the person; and (b) maintain as well as reflect his perception of his status and role in the social system.

An earlier paper described the attitudes of Negro college students toward members of widely varying ethnic, racial and reli-

gious categories (4). The present study reports an investigation of the attitudes of these students toward Jews, Negroes and nationalistic values. It attempts a further clarification of the concept of identity for Negro college students on the basis of their willingness to accept or reject ethnocentric stereotypes.

Stereotypes are defined by the majority group on the basis of their anxiety and need-determined perceptions of minorities. Stereotypes which are widely accepted by the majority group provide a frame of reference in which minority group members view their own behavior (2). Members of the minority who conform or expect others of their own group to conform to these stereotypes exemplify the "self-fulfilling prophecy." That is, the majority group predicts that minority group members will behave in a certain way and, by so doing, creates a situation which elicits the predicted behavior.

SOCIAL BACKGROUND OF SAMPLE

The study group included 102 students from sociology classes at Morgan State College in Baltimore. Morgan's population is predominantly Negro, and 56 per cent are from Baltimore City. Over 83 per cent have been reared in Maryland and other southern states. Thus, their socialization has occurred in a setting characterized by low economic status, limited educational and cultural facilities, restrictive social and political practices and racial segregation. The attempts to undo feelings of racial and social inferiority through experience at Morgan, which subscribes to the values of a liberal arts college, are modified by its historical status as a Negro institution.

At the time of testing, these students exceeded the educational level of 66 per cent of their parents. If they graduate,

they will have an education equal to or exceeding that of 95 per cent of their fathers and 87 per cent of their mothers.

The sample is 29 per cent male and 71 per cent female; sophomores comprise 30 per cent, juniors 44 per cent, and seniors 26 per cent. Most Morgan students are of upper-lower and lower-middle-class family background. When asked to evaluate their social status, 56 per cent thought their social heritage to be either lower or lower-middle class, while 23 per cent listed themselves as higher than middle class.

Over 80 per cent gave Methodist, Baptist and a few acting-out sects as their predominant religious preferences, while the remaining 20 per cent were Catholic, Presbyterian, and Episcopalian. Less than 2 per cent gave non-Negro family racial histories—American Indian or Caucasian grandparents.

HYPOTHESES

The following hypotheses refer specifically to these Negro college students: (1) Since their sociocultural background is American, a congruency of stereotypes (i.e., no statistically significant differences) exist between their views of Jews, Negroes and Americanism. (2) More support will be given to stereotypes of chauvinistic American values than to stereotypes of Negroes or Jews.

METHOD

The 20-statement, modified Frenkel-Brunswick Authoritarian Personality "E Scale" (1) was administered to the 102 students. The first six items tap Jewish stereotypes; the second six statements (7-12) are concerned with Negroes; the last eight items (13-20) are representative of American national and social stereotypes. (See Appendix I.)

Persons who give high scores on all three of these general categories are considered to be ethnocentric Americans. High scores for chauvinistic national values indicate these values as being those of the in-group, while high scores for Jews and Negroes indicate these racial and religious categories are the out-group.

Statistical analysis of the major three categories was accomplished through the use of a "t-test" for the significant difference between means. The same test was used to determine significant differences between intercategory and intracategory items. Significance refers to the 5 per cent level of confidence.

APPENDIX I

The following are statements with which some people agree and others disagree. Please mark each one in the left margin, according to the amount of your agreement or disagreement, by using the following scale:

1. strong opposition, disagreement
 2. moderate opposition, disagreement
 3. slight opposition, disagreement
 4. slight support, agreement
 5. moderate support, agreement
 6. strong support, agreement
-
- 1. One trouble with Jewish businessmen is that they stick together and prevent other people from having a fair chance in competition.
 - 2. I can hardly imagine myself marrying a Jew.
 - 3. There may be a few exceptions, but in general Jews are pretty much alike.
 - 4. The trouble with letting Jews into a nice neighborhood is that they gradually give it a typical Jewish atmosphere.
 - 5. To end prejudice against Jews, the first step is for the Jews to try sincerely to get rid of their harmful and irritating faults.
 - 6. There is something different and strange about Jews; it's hard to tell what they are thinking and planning, and what makes them tick.
 - 7. Negroes have their rights, but it is best to keep them in their own districts and

schools and to prevent too much contact with whites.

- 8. It would be a mistake ever to have Negroes for foremen and leaders over whites.
- 9. Negro musicians may sometimes be as good as white musicians, but it is a mistake to have mixed Negro-white bands.
- 10. Manual labor and unskilled jobs seem to fit the Negro mentality and ability better than more skilled or responsible work.
- 11. The people who raise all the talk about putting Negroes on the same level as whites are mostly radical agitators trying to stir up conflicts.
- 12. Most Negroes would become overbearing and disagreeable if not kept in their place.
- 13. "Zootsuiters" prove that when people of their type have too much money and freedom, they just take advantage and cause trouble.
- 14. The worst danger to real Americanism during the last 50 years has come from foreign ideas and agitators.
- 15. Now that a new world organization is set up, America must be sure that she loses none of her independence and complete power as a sovereign nation.
- 16. Certain religious sects who refuse to salute the flag should be forced to conform to such a patriotic action, or else be abolished.
- 17. Filipinos are all right in their place, but they carry it too far when they dress lavishly and go around with white girls.
- 18. America may not be perfect, but the American way has brought us about as close to a perfect society as human beings can get.
- 19. It is only natural and right for each person to think that his family is better than any other.
- 20. The best guarantee of our national security is for America to have the biggest army and navy in the world and the secret of the atom bomb.

RESULTS

These students hold American national values in highest regard. High ethnocentric scores toward chauvinistic national

values support American ideology as right, good and best. The Jewish minority is also viewed in terms of stereotypes of the American, white, Christian social world. High scores regarding the Jew indicate feelings that Jews are clannish, strange and unpredictable. Although scores toward Americanism were higher than scores toward Jews, no significant difference exists between the two.

Scores for Negro stereotypes were significantly lower than scores for either Jews or Americanism. These students did not view Negroes in terms of the white social world's Negro stereotypes. Even though a little over half the group (55 per cent) did not completely disagree with all of the stereotyped statements concerning Negroes, none of them gave greater than moderate support to any of the Negro statements, with the exception of statement 11: "The people who raise all the talk about putting Negroes on the same level as whites are mostly radical agitators trying to stir up conflicts."

Total group mean scores for the three categories were: chauvinistic national values 3.2, Jews 3.1, Negroes 1.3. Individual mean ethnocentric scores range from 1.3 to 4.9.

For the purpose of refining the data, the students were divided into two categories on the basis of their responses to the six items concerning Negroes. Those students who responded to all six of these items with a score of 1 (i.e., they rejected them) were placed in one group, referred to here as "skeptics" (N=47), and those who responded toward one or more of these statements with a score of 2 or more (i.e., they did not completely reject the statement) were placed into a second group, referred to as "believers" (N=55).

Item 11 was the criterion statement

upon which the major decision between "skeptics" and "believers" was made. There is no significant relationship between sex, place of birth, place of rearing or age, and whether one is a "skeptic" or a "believer."

According to the results of this study: Hypothesis #1 is invalid. A lack of congruency of stereotyping exists for these students. In other words, this sample of college students does not utilize the white social world's stereotype of Negroes. Hypothesis #2 is partially supported by the data. These students agree significantly more with American national stereotypes than with statements concerning Negroes. No significant difference exists in the use of American national stereotypes and stereotypes of "typical Jewish behavior."

DISCUSSION

These American Negro college students do not see themselves in terms of general American Negro stereotypes. Rejection of American Negro folk stereotypes is viewed as an indication of a newly-emerging Negro identity. This new identity for these students is inconsistent with the emerging Muslim identity of black supremacy. These students reject stereotypes concerning: the segregation of Negro housing; inability of Negroes to be leaders; segregation in employment; Negroes as manual laborers; and keeping Negroes in a socially subordinate position.

A rejection of these forms of stereotyped behavior patterns emancipates these students from subordinate social identity. No longer do they see themselves in the role of "subjugated blacks." Interestingly enough, they do not completely reject item 11. Even though this statement is not a stereotype of Negroes per se, it is an American stereotype of those persons (par-

ticularly those other than Negro) who are often found working toward equal opportunities for Negroes. This rejection may be interpreted as a search for a new identity.

The rank order of items from the "E Scale" indicates, particularly for the "skeptics," that this new social identity is: "I am an American whose family is important to me. I dislike ethnic and religious groups who do not support American ideals. I neither need nor want persons looking out for my welfare because I am socially equal to all other Americans." Even though this identity has not yet been fully obtained, these American Negro college students are actively seeking it.

"Believers" hold family in significantly higher regard than "skeptics." Family is a significant source of social identity for "believers" and "skeptics." Apparently the role of family identification is important to individuals who accept as well as those who reject culturally degrading stereotypes of their own racial group. The rank order of "E Scale" statements for "believers" indicates a personal identity that states: "My family is important to me as an American who dislikes social and religious groups who do not conform to accepted American attitudes. Even though I am an American who believes the United States is "good" and "right," I am not certain whether or not I am equal to other Americans because I see myself socially and occupationally segregated and in a subordinate position to other Americans."

"Believers," when compared with "skeptics," have significantly higher ethnocentric scores for Jewish stereotypes and American attitudes. These "believers" have adopted the prevailing stereotyped anti-minority attitudes of the white majority. This may be interpreted as an ex-

ample of identification with the aggressor (8).

CONCLUSION

The lack of congruency of stereotyping indicates that these students perceive Jews as members of the out-group, while Negroes are considered to be approaching in-group status. Since Negro stereotypes are not acceptable to these students, one might conclude that they view Negroes as individuals. Adherence to chauvinistic stereotypes for these subjects indicates a strong American-centric feeling.

"Believers" who somewhat agree with Negro stereotypes created by the white social world see family identification as significantly more important than "skeptics," who seem more secure in their Negro identity than "believers." The significantly higher scores of believers toward Jews and Americanism suggests the following hypothesis: Members of a minority who are unwilling to accept stereotypes of themselves will also be more likely to reject dominant group stereotypes of other minorities.

It seems reasonable to conclude that out of this pattern of acceptance of general American attitudes develops a diffuse, ambiguous and impersonal identity. In order for one to be a Negro, yet agree with the stereotyped statements on the "E Scale," one must be influenced by numerous identity cross-currents. For these students who were socialized under a restrictive caste system, the Negro family, the Negro church and the Negro school, autonomously operating within an American ethos which espouses equality for all but limits this equality to persons other than Negro must be a major source of an insecure sense of identity (6).

A positive, unambiguous, yet flexible

sense of identity is functional for the maintenance of mental health and social organization. The American Negro population is a necessary and vital part of the American social structure. Within the American culture, mental health and social organization are not states, but each is a process with unidentified polarities. All forms of personal disorganization lie somewhere on the negative end of the mental health continuum.

Similarly, social disorganization is merely a negative degree of social organization. Mental health and social organization are not only interrelated; they are also interdependent. The American Negro's personal identity or "social self" and his social identity or "generalized other" are functional toward the maintenance and preservation of both mental health and social structure. Therefore, the direction and degree of white-American as well as Negro-American mental health and social organization is partially dependent upon the degree to which American social organization permits the development of a positive unambiguous sense of identity for Negroes.

It can be concluded from the data concerning place of birth and rearing that both covert and overt caste restraints for these college students were equally detrimental for the development of a secure, unambiguous, flexible sense of identity. The legal removal of caste barriers is necessary for the development of a positive sense of identity, but it is not sufficient. Sufficient to a positive identity is freedom of interactional choices, commonality of communication and consensus of status and role-perception within the social structure.

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Differential teaching techniques for emotionally disturbed children

It is generally recognized that the school is an important agency in the field of mental health. However, there are divergent opinions on the specific role schools should assume.

Many educators hold that the responsibilities for mental health reside in the home and in community medical and social agencies, and not in the school. Such a view is likely to lead to policies of suspending or excluding pupils who are emotionally ill; this view may also lead to ignoring, not recognizing, and not identifying those who are emotionally disturbed. On the other hand there are educators who feel that the school should assume an active role in mental health through the regular curriculum, through special classes and special services, through identification procedures, and by co-operating in child guidance treatment.

Actually, all schools deal with emotion-

ally disturbed and neurotic children in some manner. The children's clinics and voluntary agencies have not been able to meet the needs for treatment and guidance services. The school is the only agency with compulsory obligations and responsibilities to serve the entire population of children. On the basis of the incidence of social and emotional maladjustment it can be anticipated that neurotic and disturbed children will be present in any given classroom.

The classroom experiences of these children will either be aggravating or ameliorative. The problems these children present to the classroom teachers are very complex, and there are no courses or practice teaching experiences in the teacher-education programs to prepare the teacher for

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this responsibility. This article will focus on this situation.

REVIEW OF THE LITERATURE

The lack of experimental research on the education of children with emotional illness stands in sharp contrast to the extensive interest in mental health. A number of institutional (3, 9, 13, 16) and public school programs (1, 10, 15) for emotionally disturbed children are described in the literature. A few studies (8, 12, 14) in which public school programs are subjected to research are reported. There are no experimental studies on hospital instruction for children with neuropsychiatric illness reported in the literature.

The most extensive programs of mental health in education are those of Bullis (1) and Ojemann (11). The human relations courses by Bullis and associates (2) have been used increasingly in regular classrooms throughout the country. The evaluation of these materials in supplementing the usual curricula, however, has been based largely on the users' opinions rather than on measures of the mental health of the students. Ojemann's approach (11) differs from that of Bullis in that the dynamics of human behavior are integrated into the curriculum. Basic teaching materials which illustrate this approach have been mimeographed and used in evaluative research.

One of the few experimental studies in the teaching of emotionally disturbed children in the elementary grades is that of Phillips and Haring (12). The effects of orderly, structured and control methods used in the experimental classrooms were compared to the effects of "usual" or permissive methods for other emotionally disturbed children who served as control subjects. Teachers' nominations were requested to identify the hyperactive, dis-

tractable, and withdrawn pupils. Since the nominations were based on behavioral characteristics, the identification procedures led to a heterogeneous group of emotionally disturbed. The criteria of effectiveness were teacher ratings of pre- and post-adjustment of the children.

A comprehensive evaluation of four approaches to mental hygiene was conducted by this writer (8). In an experiment utilizing eight experimental and eight control groups the following four approaches were evaluated: (A) Bullis's human relations classes (1); (B) Slavson's (16) activity method; (C) sociodrama; and (D) mental hygiene films.

The subjects for the experiment were screened from the ninth grade classes of four high schools on the basis of adjustment scores. The selection procedure led to heterogeneity in the types of maladjustment represented in the experimental groups. The criteria for evaluation, which included school grades, attendance, and pre- and post-test scores on adjustment and personality inventories, failed to disclose any significant improvement in mental health. The experimental subjects did, however, regard the classes with favorable opinions, and also showed improvements in social distance scores. Measures on these latter criteria were not available for the control subjects.

Another study which utilized an experimental design was conducted by Rosenthal (14). A variety of mental health techniques were employed with an experimental class of 26 Negro students. A control class was matched for social and intellectual characteristics. The experimental class achieved significant gains in personality and social distance scores.

Most of the public school systems in the major cities in the country offer various classroom programs for the mental health

of normal as well as emotionally disturbed children. Although there is a general lack of validating research, these programs reflect the widespread and genuine interest of educators. Hertzman (7), who served as a consulting psychiatrist in the Cincinnati, Ohio schools, described the high school courses in human relations. Goldsmith, *et al.* (6) reported attempts in the educational treatment of delinquents for the New York City schools. The Los Angeles city schools have had "adjustment classes" for the educational management of socially and academically maladjusted students. References to programs in other cities also appear in the literature.

One of the major objectives of the Forest Hills Village Project (15) was to render mental health services through the schools and its associations. Even though this was a community project the schools were utilized as the major vehicle for conveying mental health education and services to parents and children.

Ferster and De Meyer (5) carried out comprehensive analyses of the performance of autistic children and postulated experiential bases for behavior deficits. Ferster (4) then experimented with reinforcement procedures toward establishing meaningful behavioral responses in autistic children. He was successful in developing systematized complex responses using candy, music and coins as reinforcers.

Although the autistic behavior was not generally extinguished, the fact that it was amenable to change through operant conditioning holds important significance for education. First, the theoretical origin of this approach is identified. Secondly, it is based on a functional analysis of behavior rather than on traditional psychiatric classifications. Finally, it leads to experimental procedures which can be evaluated in research.

The failure of these procedures to effect a general reduction of autistic behavior tends to invalidate the concept of reinforcement history and the socio-interactional aspects of this theory. The fact, however, that certain behavior of autistic children could be experimentally controlled may eventually have more significance for educational method than for personality theory.

DIFFERENTIAL TEACHING METHODS

There is no agreement or common view among educators and psychiatrists that special teaching techniques or special educational treatments for emotionally disturbed children are valuable or necessary.

It is apparent that an emotional handicap tends to reduce the educability of the child but its precise effect on achievement and pupils' behavior is not very well-known or understood. Such symptoms as fear, withdrawal, anxiety, daydreaming, fantasy, emotional regression and defensive lying may not be sufficiently apparent for the teacher's recognition and consideration. Also, the emotional needs of some disturbed children are satisfied through achievement performance, and the teacher may then overlook or fail to recognize this as a symptom.

The management of acting-out behavior, however, is undoubtedly the most difficult problem in teaching children with emotional disturbance. This behavior is usually boisterous, disruptive and idiosyncratic. It is symptomatic in nature and may be observed in the majority of these children. To encourage or discourage this behavior in the classroom situation may actually serve to reinforce it. The child's expression of acting-out behavior may not have much therapeutic value, and it may actually serve further to alienate the child from his peers and from adults. Since this

behavior is symptomatic it should probably not receive differential treatment in either educational or social groups. Specific educational treatments might provide negative or positive reinforcements toward its continuance.

In the course of the past four decades, there have evolved from the field of mental

hygiene some concepts that are now commonly held in education and psychiatry. These would include such views as: (1) the creative expression of children should be encouraged; (2) children's interests and self-directed activities have educational value; (3) frustration and anxiety should be avoided because of their detrimental

General Concepts in Teaching for Mental Health

General view	Rationale or source	Argument against
Creative expression of the child should be encouraged.	Psychoanalytic theory, projection of emotional problems and conflict.	An emotionally insecure child may be made more insecure. An insecure child would lack initiative and spontaneity for creative expression. Imitative expression may serve better to fulfill dependency needs.
Children's interests and self-directed activities have educational value.	Progressive education and pragmatic philosophy.	The self-directed activities of a compulsive child are neither educational nor therapeutic. The interests of a child who is emotionally preoccupied would be too restricted to guide a child's educational experiences.
Frustration and anxiety should be avoided because of detrimental effect on personality.	Clinical evidence and animal experimentation on conditioning and neuroses.	The constitutional psychopath would show shallow anxiety and intolerance to frustration. Efforts might be directed to heighten anxiety and improve tolerance to frustration.
Drill and practice have a negative effect on motivation.	Experiments in school learning.	A child with neurological impairment affecting kinesthetic or perceptual abilities may enjoy and profit from specific drill or practice. Repetition may improve neurochemical and metabolic efficiency.
Teaching should be directed toward the "whole child."	Organismic theory and evidence on the inter-relatedness of physical systems.	A child with a segmental disability resulting from neural lesions or dysfunction is not a "whole child" in the usual sense of this term. Educational and psychiatric treatment may be directed toward development of assets rather than total function.
Activity is healthy.	Child development: maturation is based on nurture and activity.	A hyperactive child, for whom behavior is emotionally or organically driven, may need medical or environmental constraint over activity. Organism may require "containment" and physical support for physical security.

effect on personality; (4) drill and practice have a negative effect on motivation; (5) teaching should be directed toward the whole child; and (6) activity is healthy.

These are just a few such concepts which prevail. They have their origins in both theory and research, and, in general, they seem to represent sound principles for the education of normal children. Educational practices have, to a large extent, been based on and justified by these concepts. In the teaching of emotionally disturbed children, however, they may actually be ineffective and also detrimental to the mental health of the particular child.

The following chart lists some of these general views and their sources. It also presents the specific arguments against their use for particular types of emotionally disturbed children.

It can be seen in the above chart that the general principles relating to mental hygiene in the schools have come from a variety of sources and that they are now represented in a variety of curriculum practices. For specific cases, however, these general principles would not hold for children who are emotionally disturbed. The historical tendency has been to establish these general principles or concepts in mental health education and then to apply them to all children through the curriculum. For purposes of this discussion this might be defined as a deductive approach to mental health teaching.

In contrast, this paper proposes an inductive approach. This assumes that there are individual and group differences in the educational needs of children which are based on psychological and constitutional factors. The varying influences of these factors should require the development of different objectives and different techniques.

An attempt to illustrate the differen-

tial inductive approach to teaching emotionally disturbed children is shown in the chart on page 214.

The above chart does not detail the specific kind of teaching behavior or curriculum activity which should effect the intended objectives. Before proceeding with the curriculum application, perhaps the theoretical validity of the recommendations should be considered.

There are two obvious deficiencies to this kind of "cookbook" approach to mental health. The first criticism is that personality classifications of emotionally disturbed children are not sufficiently valid or distinct to serve as a basis for curriculum objectives. The classification of children on the basis of psychiatric categories is of questionable value for educational purposes. The problem, however, is that differential treatments should be based on differential diagnoses of some kind. Discrimination in the choice of therapeutic or educational methods is possible only with a distinct qualitative classification for the child.

A second criticism relates to the separation of functions, or the partition of the individual according to aspects of his development. It is recognized that intellectual, social, and emotional development are not discrete and independent processes. To account for the interrelationships of functions, however—through pairing or conjoining of several related functions—would require more distinctions than are currently listed.

A third criticism would be that this approach does not recognize differences in the dynamics of emotional development. The question arises as to whether certain groups of children could be classified on the basis of similarity in emotional history, or in the dynamics of their adjustments to emotional experience. Still

Differential Approach for Educating Emotionally Disturbed Children

Areas of function	Classifications of Personality			
	Organic CNS impairment	Obsessive compulsive	Autistic	Depressive withdrawal
Intellectual	Help direct and maintain attention. Reinforce through repetition. Emphasize overlearning of simpler essential concepts.	Expand attention from preoccupation. Expand concept. Introduce new learning. Adaptive learning.	Arouse attention for learning stimuli. Teach problem-solving. Reinforce infantile expression at level of development.	Externalize attention to develop interests. Introduce new learning materials.
Emotional	Help form a stable identification. Deepen or intensify feelings. Help child to a cognizant awareness of feeling. Help child to moderate extreme expressions of emotion.	Desensitize or recondition fear or anxiety responses. Identify and reflect feelings, needs, expression. Widen emotional security.	Encourage overt expression of feeling. Help child obtain real satisfaction through vicarious means—reading, writing, magic, etc. Bring out symbolic expression of fantasies.	Uncover conflicts. Overt expression of anger. Expressive release.
Social	Limit social interactions to those the child can contain. Teach respect for few; to generalize to more.	Create new social patterns through different peer relationships.	Establish firm dependency relationship to adult. Transfer to other adults and children.	Attempt single and sincere association. After relationship is formed, encompass several other friendships and activities.
Speech and language	If dysphasic, promote oral and written vocabulary.	Limit verbal expression of compulsive patterns. Diminish repetitive responses.	Increase vocal expression—laughing, mimicry, and vocal communication.	Help child to verbalize feelings—negativism in oral expression.
Perceptual	Employ kinesthetic cues. Intensify sensory stimuli where there is associational loss.	Broaden perceptual field. Indicate emotional influences which alter fear and compulsive patterns.	Have child relate to material environment.	Extend perceptual field.
Kinesthetic	Determine scope of movement skills. Reinforce physical skills. Develop patterns for new skill; e.g., learn by tracing. Work from gross toward finer physical movements. Physically supportive contacts.	Encourage gestural expression. Promote physical participation in games, dance, etc.	Gesture and postural expression. Contact through holding hands, walking, pat on shoulder.	Move from aggressive physical actions to constructive—example: cutting, papier-maché, etc.

others might question the validity of this model in that it does not give direct consideration to ego and superego processes and libidinal needs.

Perhaps the best way to evolve an acceptable model before proceeding to its testing would be to have a number of authorities propose differential treatments or objectives, using other dimensions. The relationships or agreements among objectives indicated in the cells could then be analyzed for common factors.

If mental health authorities and educators could arrive at a mutually acceptable model, the educator would still be faced with the task of determining what teaching actions and curriculum activities would best effect the objectives.

There are two contradictory viewpoints in regard to translating objectives into methods: The first of these holds that after the teacher learns the appropriate objective for the child's emotional growth—and perhaps also knows the principle or theoretical basis from which it was evolved—she will be able to select the appropriate curriculum activity and act in such a manner that the objectives can be realized.

The other viewpoint is that even though the teacher may know the objective and its theoretical source, she would still be at a loss to determine the subsequent teaching and curriculum actions. To illustrate this problem further, it is probable that any given instructional activity would result in a different curriculum experience for different pupils, because of the manner in which the teacher presented it and also because of the particular perceptions and interpretations of the pupil.

If differential education can be employed on an experimental basis, it is possible that a functional classification of emotionally disturbed children on the

basis of their educational characteristics may eventually be established.

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Impairment of psychiatric outpatients and change with treatment

In the United States, through nationwide reporting for outpatient psychiatric clinics (9, 11, 15), the demographic and diagnostic characteristics of patients and services they receive have been studied in detail (1, 2, 3, 4, 10, 13). Data on impairment associated with mental illness are lacking, however, and change following treatment is reported only by the classification "improved," or "unimproved" or "worse."

This paper explores some methodology in the use of three relatively simple scales to describe the impairment of outpatients before and after treatment. The data used were obtained from the clinics at St. John's Hospital (for mental diseases), Aylesbury, England.

METHOD

During the period of the survey (1959 and 1960), data were collected on every patient's

first visit at any of the three outpatient clinics of the hospital. Where psychiatric consultation of any kind had occurred during the previous six months, the referral did not qualify as a "first visit." Basic demographic characteristics and disposition were recorded. In addition, ratings of impairment on three scales to be described later were made.

The diagnosis was given by the psychiatrist and coded according to the International Classification of Diseases. Where an abnormality of intelligence or personality was present, in addition to the primary

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disorder, this was recorded separately. Social class was determined from occupation (or husband's occupation) according to the registrar-general's classification.

About one-third of patients had more than one visit to the clinic; they are referred to as "treated patients." At the time of their discharge, or approximately three months after their first visit—whichever was earlier—a second rating on the same three scales was recorded. The initial rating was not available for reference at the time of the second rating. The two ratings may be considered independent, therefore, although both were usually made by the same psychiatrist.

Rating scales and their definitions. Three major areas of functioning were delineated, and scales for each area constructed as follows:

Symptoms or social disturbance	0. none
	1. mild
	2. moderate
	3. severe
Occupation (or school)	0. unaffected
	1. working with difficulty
	2. work severely affected
	3. unable to work
Social (or marital) relations	0. unaffected
	1.5 moderately disturbed
	3. severely disturbed

The three functional areas were considered as mutually exclusive in the sense that each is focused in a different frame of reference. Together they cover most aspects of the patient's life adjustment. No written instructions or definitions were provided the rater (psychiatrist). However, the scope and focus of each area, in practice, was as follows:

The *symptoms or social disturbance* area was intended to include (1) somatic symptoms, (2) disorganization of thought or perception, (3) mood disturbances, (4) special

symptom reactions such as enuresis and speech disturbances, and (5) socially unacceptable behavior, such as fire setting, drug addiction, and stealing. Such behavior as alcoholism and suicide attempt would be included in the scope of this scale.

The *occupation (or school)* area was focused on work performance. This would include, for students, academic underachievement and reading problems; for adults, reduced productivity on the job or in housework, including inability to work at all.

The *social (or marital relations)* area described *interpersonal* relations in the home, community, school, work situation, etc. Impaired relationships may be characterized by withdrawal, aggressive or dependent behavior, and marital conflict.

An explanation of the method of analysis of the scales is given in the Appendix.

FINDINGS

Impairment in the total clinic population. In 1959 and 1960, 1,084 patients were admitted to St. John's Hospital outpatient service with a new or recurrent illness. Appendix Table 1 provides some basic information on the patients' demographic and diagnostic characteristics, and their disposition.

Almost all patients must be accounted disabled by their psychiatric illness (Tables 1 and 2). Only 10 per cent were free of symptoms or social disturbance (Table 1). Over 60 per cent were working at reduced efficiency, including 18 per cent unable to work at all. More than half had impaired interpersonal relations. Patients were much more likely to be impaired in two or three functional areas than in only one.

On the average, impairment was greater

TABLE 1

Distribution of total patients by level of initial impairment, by area of functioning

Area of functioning and level of impairment	Number			Per cent		
	Total	Male	Female	Total	Male	Female
Total patients	1,084	465	619	100.0	100.0	100.0
Symptoms or social disturbance						
None	109	57	52	10.1	12.3	8.4
Mild	353	143	210	32.6	30.8	33.9
Moderate	410	172	238	37.8	37.0	38.4
Severe	204	91	113	18.8	19.6	18.3
Not stated	8	2	6	0.7	0.4	1.0
Occupation (or school)						
Unaffected	414	192	222	38.2	41.3	35.9
Working with difficulty	342	117	225	31.5	25.2	36.3
Work severely affected	108	33	75	10.0	7.1	12.1
Unable to work	193	111	82	17.8	23.9	13.2
Not stated	27	12	15	2.5	2.6	2.4
Social (or marital) relations						
Unaffected	477	225	252	44.0	48.4	40.7
Moderately disturbed	396	147	249	36.5	31.6	40.2
Severely disturbed	177	76	101	16.3	16.3	16.3
Not stated	34	17	17	3.1	3.7	2.7

in the area of symptoms than in either occupation or social relations (Table 3). The total mean impairment score for all three areas was 3.9. When this is related to the maximum possible impairment score of 9, a relative incapacity of 43 per cent for the patient population is obtained.

The distribution of patients by total impairment score (Figure 1) is somewhat skewed toward the upper ratings.¹ Four per cent of the patients had the maximum score, 9 levels of impairment.

Impairment in patient subgroups. Comparison by sex indicates that the total mean impairment is slightly greater for females than males. Males and females do not differ significantly in symptom ratings. In occupation, their mean impairment is similar, but more of the males are rated at either end of the scale (with-

out impairment or unable to work), while more of the females are classified as working with some or severe difficulty.

In social relations, more of the females are moderately impaired and fewer unaffected. Just as occupational impairment may determine male referrals to the clinic, difficulties with interpersonal relations may be an important selective factor for females.

Both boys and girls under 15 years of age have more than average impairment in symptoms; girls have more than average impairment in social relations (Figure 2). Symptomatology declines with age until 25-34 years and then begins to rise again with advanced age. Impairment

¹ The mean score (3.9) is therefore greater than the median (3.4).

TABLE 2

Distribution of total patients by initial impairment in all three areas of functioning

Area of functioning and presence of impairment	Number			Per cent		
	Total	Male	Female	Total	Male	Female
Total patients	1,084	465	619	100.0	100.0	100.0
Some impairment in:						
No area	48	26	22	4.4	5.6	3.6
One area—total	228	111	117	21.0	23.8	18.9
Symptoms	184	87	97	17.0	18.7	15.7
Occupation	22	15	7	2.0	3.2	1.1
Social relations	22	9	13	2.0	1.9	2.1
Two areas—total	377	158	219	34.8	34.0	35.4
Symptoms and occupation	216	91	125	19.9	19.6	20.2
Symptoms and social relations	145	61	84	13.4	13.1	13.6
Occupation and social relations	16	6	10	1.5	1.3	1.6
Three areas	381	143	238	35.1	30.8	38.4
Not stated *	50	27	23	4.6	5.8	3.7
Severe** impairment in:						
No area	604	232	372	55.7	49.9	60.1
One area—total	265	133	132	24.5	28.5	21.3
Symptoms	44	23	21	4.1	4.9	3.4
Occupation	156	83	73	14.4	17.8	11.8
Social relations	65	27	38	6.0	5.8	6.1
Two areas—total	100	55	45	9.3	11.8	7.2
Symptoms and occupation	56	26	30	5.2	5.6	4.8
Symptoms and social relations	30	20	10	2.8	4.3	1.6
Occupation and social relations	14	9	5	1.3	1.9	0.8
Three areas	65	18	47	6.0	3.9	7.6
Not stated *	50	27	23	4.6	5.8	3.7

* Patients who were not rated in one or more areas of functioning.

** Severe impairment is defined as (a) symptoms rating of "severe," (b) occupational ratings of "work severely affected" or "unable to work" and (c) social relations rating of "severely disturbed."

in work performance begins to increase rapidly at 45-54 years, particularly for males. Social relations impairment, on the other hand, shows no distinct age trend.

The single patient, widowed female, and separated or divorced male has greater symptomatology than persons in other

marital categories. Occupational difficulty is greatest for the widowed, separated or divorced male. The occupational impairment of single and married women differs significantly, the distribution of single women resembling that of men. Social relations impairment is reported highest for the single, separated or divorced, next

TABLE 3

Initial mean level of impairment and per cent of maximum possible score for total patients, by area of functioning and total for three areas

Area of functioning	Total		Male		Female	
	Mean level	Per cent of maximum possible score	Mean level	Per cent of maximum possible score	Mean level	Per cent of maximum possible score
Symptoms or social disturbance	1.66	55.3	1.64	54.6	1.67	55.7
Occupation (or school)	1.15	38.3	1.14	38.0	1.15	38.3
Social (or marital) relations	1.07	35.7	1.00	33.3	1.12	37.3
Total for three areas	3.88	43.1	3.78	42.0	3.94	43.8

highest for the married, and minimal for the widowed.

Differences by marital state are not accounted for by age factors. At every age

level, total impairment is greater for single than married males. Similarly, for most age groups single females are more impaired than the married.

FIGURE I
PERCENT DISTRIBUTION OF ALL PATIENTS BY TOTAL IMPAIRMENT SCORE, INITIAL RATING

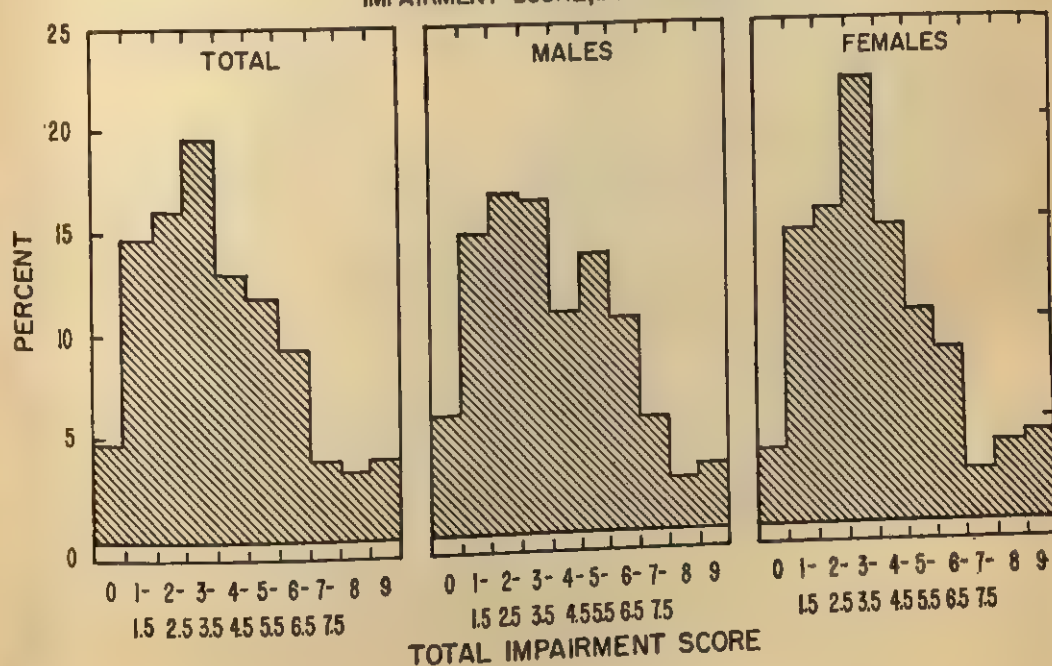
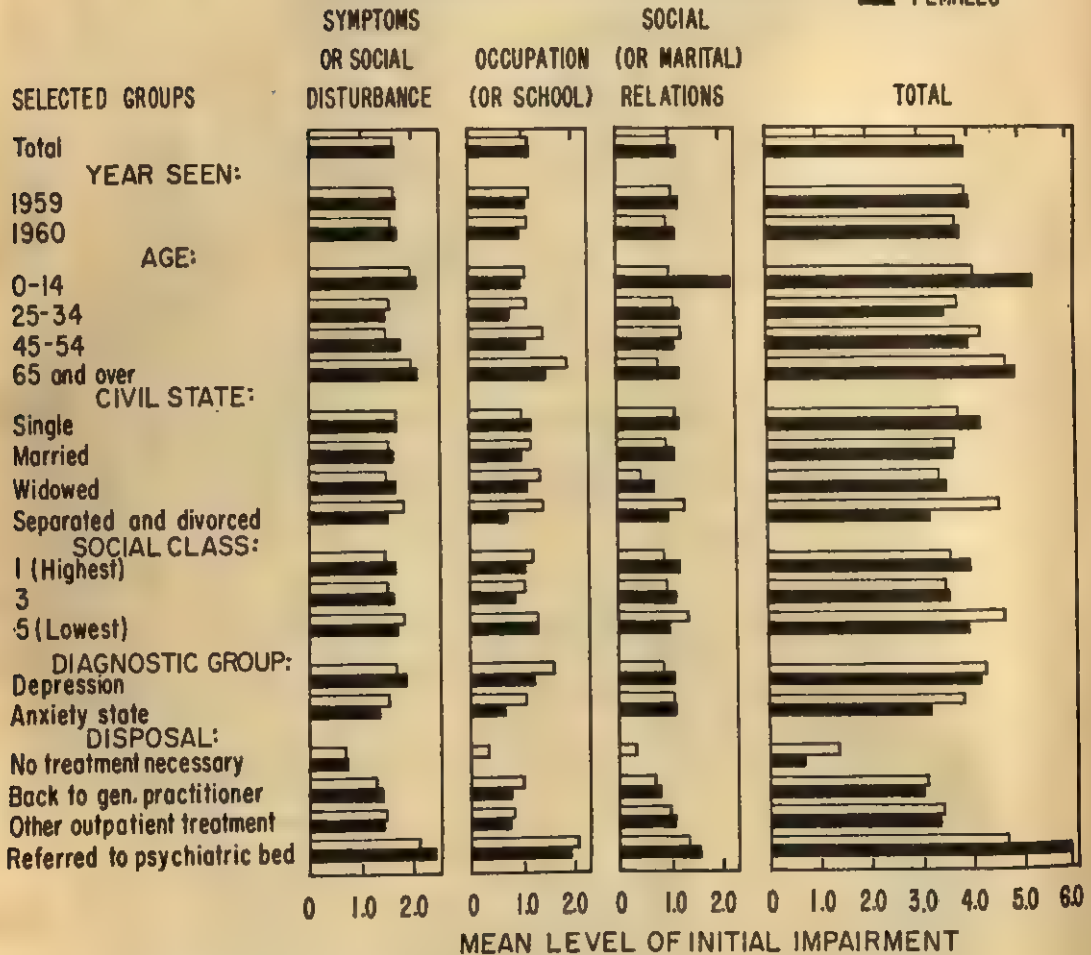


FIGURE 2

MEAN LEVEL OF INITIAL IMPAIRMENT
FOR SELECTED GROUPS, TOTAL PATIENTS

MALES
FEMALES



The most striking finding by social class is the high occupational impairment for both males and females of the lowest class (Class 5), and the considerable impairment in symptoms and social relations for lower class males. The high impairment scores for those with social class "not stated" suggest that they may be from Social Class 5.

Patients without any previous psychiatric consultation are less impaired than

others. Patients with depression or "other functional psychosis," including schizophrenia, are most impaired, while persons with anxiety state (especially females) or with other neuroses are generally rated least impaired.

As would be expected, there is a direct relation between impairment level and disposition. Impairment is lowest for those not recommended for treatment and highest for those referred for a psychiatric

bed. The general practitioner takes cases almost as seriously impaired as those referred for further outpatient clinic treatment.

Comparison of patients before and after treatment. Of the 1,084 total patients, 338 or 31 per cent, were actually treated in the

clinics (Appendix Table 1). The initial impairment of treated patients was, on the average, lower than that of other patients, and relatively fewer had severe impairment (Tables 3 and 13). In addition, some differential selection of treated cases by sex is evident. Whereas the mean score for

APPENDIX TABLE 1

Distribution of total patients and of treated patients, by age group, civil state, social class, previous consultation, diagnostic characteristics, and disposal

Selected groups	Total patients			Treated patients		
	Total	Male	Female	Total	Male	Female
Total	1,084	465	619	338	132	206
Age:						
0-14 years	28	18	10	10	7	3
15-24 "	185	97	88	41	17	24
25-34 "	245	101	144	82	29	53
35-44 "	274	114	160	105	43	62
45-54 "	140	57	83	40	16	24
55-64 "	107	42	65	30	10	20
65 and over	66	22	44	13	5	8
Not stated	39	14	25	17	5	12
Civil state:						
Single	293	168	125	84	41	43
Married	659	250	409	212	74	138
Widowed	45	7	38	14	2	12
Separated	20	13	7	3	2	1
Divorced	11	3	8	5	3	2
Not stated	56	24	32	20	10	10
Social class:						
1 (Highest)	56	26	30	16	3	13
2	156	71	85	50	25	25
3	445	202	243	128	59	69
4	127	59	68	52	21	31
5 (Lowest)	69	41	28	13	5	8
Not stated	231	66	165	79	19	60
Previous consultations:						
None	704	301	403	222	84	138
At St. John's	61	26	35	19	11	8
Elsewhere	183	88	95	55	21	34
Not stated	136	50	86	42	16	26

APPENDIX TABLE 1—(Continued)

Selected groups	Total patients			Treated patients		
	Total	Male	Female	Total	Male	Female
Diagnostic group:						
Depression—neurotic	51	15	36	23	8	15
psychotic	410	131	279	144	45	99
Anxiety state	215	91	124	82	31	51
Other functional psychosis	61	32	29	17	9	8
Other neurosis	58	24	34	17	6	11
Personality disorder alone	71	53	18	13	12	1
Other disorders	130	74	56	30	18	12
Without psychiatric illness	84	43	41	12	3	9
Defect:						
No abnormality of personality or intelligence	985	411	574	305	115	190
With abnormality of personality or intelligence	94	51	43	33	17	16
Disposal:						
No treatment necessary	21	14	7	..	..	..
Back to general practitioner	262	108	154	..	..	..
Further outpatient appointment	491	185	306	..	..	..
Referred or admitted to psychiatric bed	211	92	119	..	..	..
Other and not stated	99	66	33	..	..	..

all females was higher than for males, for treated females it was lower than for treated males.

A comparison of the ratings of all treated patients before and after treatment (Tables 4 and 5) reveals marked improvement for the group in each area of functioning. The proportion of patients without impairment in any area increased from 2 to 28 per cent, and without any severe impairment from 62 to 80 per cent. Whereas 70 per cent were impaired in two or three areas before treatment, after treatment only 34 per cent were so rated. Symptoms was the principal area of mild or moderate residual impairment; but occupation and social relations were the principal remaining areas of severe impairment.

Only a few of the principal findings on

movement of individual patients can be noted. Almost 60 per cent of the patients improved in symptoms, compared with 42 per cent in work performance and 33 per cent in social relations (Table 6). However, more patients were initially impaired in symptoms than in other areas. In each area, about a tenth of the patients showed deterioration.

Of those who could improve or deteriorate, more improved in the area of occupation than in symptoms or social relations (Table 8). However, of those who could improve only, the greatest proportion improved in symptoms; while among those who could deteriorate only, the symptom-free persons showed the greatest proportion deteriorated in that area. This suggests either greater mobility at both

ends of the symptom scale or that we are dealing with problems in ascertainment of symptoms at the time of initial consultation.

Sixty-nine per cent improved in general; that is, they gained more levels in all functional areas than they lost (Figure 3).

In occupation, impaired patients who improved tended to achieve maximum possible improvement (Tables 9 and 10). This tendency was not as evident in social relations, while for symptoms the per cent gain for those who improved was least of all.

In each functional area, the gain for the total group was partially offset by a loss of approximately one-tenth of a level (Table 11). The net gain represented a decline of around 45 per cent in symptoms

and in social disability and 54 per cent in occupational disability. The mean decline following treatment in total impairment score was 47 per cent; i.e., from 3.5 to 1.9 (Tables 12 and 13).

Net change in treated patient subgroups. Overall, the sexes do not differ markedly in the direction or amount of change. When examined by age, social class, and diagnostic group, however, differences by sex are quite marked (Figure 4 and Table 13).

Females 15-24 years of age showed much more improvement than males. Males between 25 and 44 generally improved more than females, while older females did somewhat better than males.

Single males tend to improve somewhat less than married males except in social

TABLE 4

Per cent distribution of treated patients by level of impairment, by area of functioning: Comparison of initial and second ratings

Area of functioning and level of impairment	Total		Male		Female	
	Initial rating	Second rating	Initial rating	Second rating	Initial rating	Second rating
Number of patients	338	338	132	132	206	206
Symptoms or social disturbance						
None	9.5	35.2	11.4	38.6	8.3	33.0
Mild	36.7	44.4	30.3	41.7	40.8	46.1
Moderate	39.6	16.3	42.4	14.4	37.9	17.5
Severe	13.9	3.8	15.9	5.3	12.6	2.9
Not stated	0.3	0.3	0.0	0.0	0.5	0.5
Occupation (or school)						
Unaffected	39.3	73.1	37.1	73.5	40.8	72.8
Working with difficulty	37.6	14.8	34.1	12.1	39.8	16.5
Work severely affected	7.1	1.5	6.1	0.8	7.8	1.9
Unable to work	13.9	8.3	20.5	12.1	9.7	5.8
Not stated	2.1	2.4	2.3	1.5	1.9	2.9
Social (or marital) relations						
Unaffected	45.0	66.3	46.2	63.6	44.2	68.0
Moderately disturbed	39.6	22.2	37.1	24.2	41.3	20.9
Severely disturbed	13.3	7.7	12.1	8.3	14.1	7.3
Not stated	2.1	3.8	4.5	3.8	0.5	3.9

TABLE 5

Per cent distribution of treated patients by impairment in all three areas of functioning: Comparison of initial and second ratings

<i>Area of functioning and presence of impairment</i>	<i>Total</i>		<i>Male</i>		<i>Female</i>	
	<i>Initial rating</i>	<i>Second rating</i>	<i>Initial rating</i>	<i>Second rating</i>	<i>Initial rating</i>	<i>Second rating</i>
Number of patients	338	338	132	132	206	206
Some impairment in:						
No area	2.1	27.5	2.3	28.8	1.9	26.7
One area—total	24.3	34.0	25.7	31.8	23.2	35.5
Symptoms	18.0	28.1	17.4	25.0	18.4	30.1
Occupation	3.3	1.2	5.5	1.5	1.9	1.0
Social relations	3.0	4.7	3.0	5.3	2.9	4.4
Two areas—total	37.6	21.9	34.9	23.4	39.4	20.9
Symptoms and occupation	21.0	9.5	20.5	8.3	21.4	10.2
Symptoms and social relations	15.7	11.8	14.4	13.6	16.5	10.7
Occupation and social relations	0.9	0.6	0.0	1.5	1.5	0.0
Three areas	32.5	12.1	31.1	11.4	33.5	12.6
Not stated*	3.6	4.4	6.1	4.5	1.9	4.4
Severe** impairment in:						
No area	62.4	79.9	55.3	75.8	67.0	82.5
One area—total	24.8	12.1	28.8	15.1	22.3	10.3
Symptoms	5.3	0.6	6.1	0.8	4.9	0.5
Occupation	12.7	6.8	17.4	9.8	9.7	4.9
Social relations	6.8	4.7	5.3	4.5	7.7	4.9
Two areas—total	5.7	1.8	7.6	3.1	4.4	1.0
Symptoms and occupation	3.0	0.6	3.8	0.8	2.4	0.5
Symptoms and social relations	1.8	0.9	3.0	2.3	1.0	0.0
Occupation and social relations	0.9	0.3	0.8	0.0	1.0	0.5
Three areas	3.6	1.8	2.3	1.5	4.4	1.9
Not stated*	3.6	4.4	6.1	4.5	1.9	4.4

* Patients who were not rated in one or more areas of functioning.

** Severe impairment is defined as (a) symptoms rating of "severe," (b) occupational ratings of "work severely affected" or "unable to work" and (c) social relations rating of "severely disturbed."

relations, while the reverse is true for females; however, age may be a factor in these differences. Gains are relatively high for single females in social relations and for married males in occupation.

For males there is a distinct relationship between social class and improvement. In each functional area, improvement tends to increase with lower social class. For

females, the slight differences by social class suggest the opposite trend. Males of lower social class, typically referred because of occupational impairment, showed marked occupational gains.

Both males with depression and those with anxiety state and females with depression showed a net gain of 57 per cent or better. For female anxiety cases, however,

TABLE 6

Distribution of treated patients by movement between initial and second ratings, by area of functioning

<i>Area of functioning and movement</i>	<i>Number</i>			<i>Per cent</i>		
	Total	Male	Female	Total	Male	Female
Number of patients*	314	120	194	100.0	100.0	100.0
Symptoms or social disturbance						
Improved	184	71	113	58.6	59.2	58.2
No change	96	35	61	30.6	29.2	31.4
Deteriorated	34	14	20	10.8	11.7	10.3
Occupation (or school)						
Improved	131	52	79	41.7	43.3	40.7
No change	156	56	100	49.7	46.6	51.5
Deteriorated	27	12	15	8.6	10.0	7.7
Social (or marital) relations						
Improved	104	35	69	33.1	29.2	35.6
No change	184	73	111	58.6	60.8	57.2
Deteriorated	26	12	14	8.3	10.0	7.2

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

TABLE 7

Distribution of treated patients by movement between initial and second ratings in all three areas of functioning

<i>Movement</i>	<i>All patients</i>			<i>Patients with some initial impairment in all three areas</i>		
	Total	Male	Female	Total	Male	Female
Number of patients*	314	120	194	103	39	64
Per cent distribution with:						
No change in any area	14.0	13.3	14.4	5.8	10.3	3.1
Improved in at least one area, deteriorated in no area	65.3	64.2	66.0	81.6	74.4	85.9
Improved in no area, deteriorated in at least one area	13.1	12.5	13.4	7.8	7.7	7.8
Improved in at least one area and deteriorated in at least one area	7.6	10.0	6.2	4.9	7.7	3.1

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

TABLE 8

Distribution of treated patients according to whether they could improve or deteriorate, improve only, or deteriorate only, by movement and by area of functioning

<i>Movement</i>	<i>Symptoms or social disturbance</i>			<i>Occupation (or school)</i>			<i>Social (or marital) relations</i>		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Total number of patients: *	314	120	194	314	120	194	314	120	194
<i>Patients who could improve or deteriorate:</i>									
Number	241	88	153	141	48	93	123	46	77
Per cent: Improved	61.0	62.5	60.1	72.3	75.0	71.0	60.2	52.2	64.9
Deteriorated	9.1	9.1	9.2	7.8	12.5	5.4	6.5	10.9	3.9
Unchanged	29.9	28.4	30.7	19.9	12.5	23.7	33.3	37.0	31.2
<i>Patients who could improve only:</i>									
Number	44	19	25	43	24	19	43	15	28
Per cent: Improved	84.1	84.2	84.0	67.4	66.7	68.4	69.8	73.3	67.9
Unchanged	15.9	15.8	16.0	32.6	33.3	31.6	30.2	26.7	32.1
<i>Patients who could deteriorate only:</i>									
Number	29	13	16	130	48	82	148	59	89
Per cent: Deteriorated	41.4	46.2	37.5	12.3	12.5	12.2	12.2	11.9	12.4
Unchanged	58.6	53.8	62.5	87.7	87.5	87.8	87.8	88.1	87.6

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

the gain was only 23 per cent. Before treatment, females with anxiety state had lower total impairment than did females with depression, but after treatment the former had relatively higher impairment.

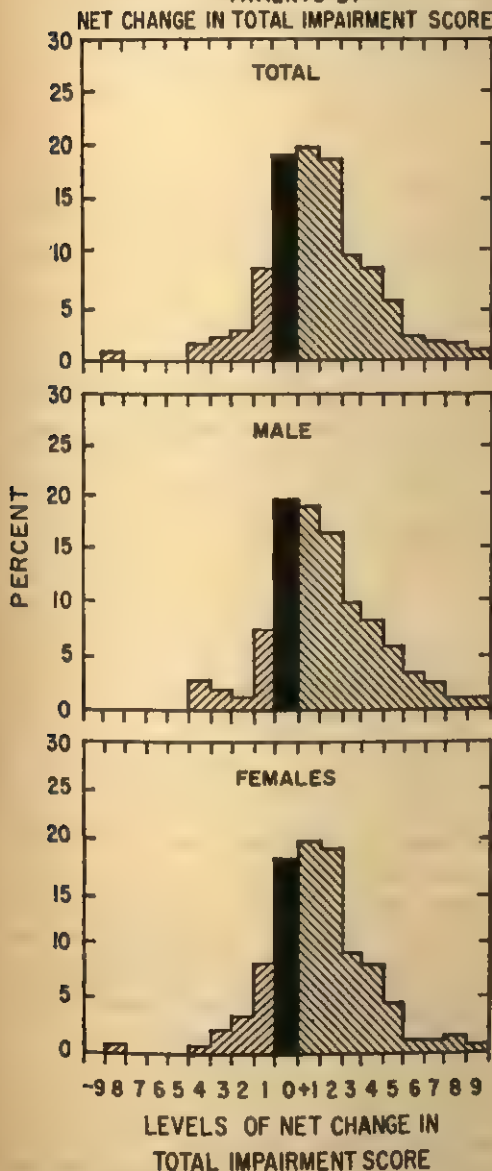
Of possible clinical significance, particularly in reference to "crisis" therapy, is the suggestion that it may be more difficult for those mildly (or moderately) impaired to "improve" than for those severely affected. Patients with above average initial total impairment scores (4 or more) removed, on the average, 57 per cent of their initial impairment, while those with lower initial scores improved only 19 per cent. An exception are mildly impaired men

with anxiety state who gained as much as those severely impaired.

Both delay in recognition of impairment and further progression of incipient disease, however, may be more apt to be factors in the mild case than in the severe. This is consistent with the finding that the initially less impaired are more likely to be rated as having deteriorated.

Discussion of treatment outcome. All the criteria used show that a considerable improvement took place among the 338 patients who returned to the clinic for further visit. The proportion which can be accounted "recovered" (defined as the increase in the proportion showing no

FIGURE 3
PERCENT DISTRIBUTION OF TREATED
PATIENTS BY



impairment) is small, however; 26 per cent for symptoms, 24 per cent for occupation, 21 per cent for social relations, and 25 per cent over-all.

Mild residual impairment is contribu-

ted chiefly by symptoms, but severe impairment is almost wholly due to occupation and social relations. It is clear, therefore, that a proportion of patients whose symptoms were relieved remained out of work or estranged from family and friends. Whether the residual impairment can be attributed entirely to problems associated with the illness is not known.

The differences between men and women by age, social class and diagnosis are of interest. In men, the greatest improvement took place in the age group 25-44, while younger and older women are most improved. In younger women the more marked improvement in social relations compared with men accounts for their greater net gain and may be attributable to the higher incidence of schizophrenia among young men.

In the older age group, the higher proportion of women than men with depression, which carries a good prognosis, probably accounts for their better outcome. The poor response of women with anxiety state as compared either with men with anxiety state or with depressions in both sexes is an unexpected finding. The sexes had about the same proportion of anxiety states in all patients and in treated patients, making it unlikely that differences in diagnostic standards or in selection for treatment account for the discrepancy in outcome.

Some comment may be helpful in evaluating changes in work disability. Patients can be classified by occupation into those who are employed and those who work for themselves. Employed persons, falling ill, stop work when their efficiency is conspicuously impaired and are not likely to return until recovery is sufficient to restore working capacity to a high level. Self-employed persons, such as housewives,

on the other hand, will continue *some* work so long as they have *any* capacity for it and will resume it with impaired efficiency when still at a low level of improvement.

Since absence from employment and its resumption obtain the most severe and the least estimates of incapacity, respectively, on our rating scale, change from one to the other results in a maximum transposition. This is shown among men and single women, the subgroups constituted principally of persons employed outside the home. The trend is most marked among males of Social Classes 4 and 5, and is mainly responsible for the inverse relation between improvement and social class in males.

The lower social group of men is likely to be reduced to living on National Health Insurance during absence from work. The

pressure to improve income and the more regular review of incapacity by the general practitioner, which the issue of National Health Insurance certificates necessitates, may expedite return to work.

DISCUSSION OF SCALES

We should like to review several aspects of the scales, their limitations and usefulness, as criteria for measuring impairment in an outpatient population.

Applicability. Perhaps the first asset of a scale is its applicability—its importance to the investigation and appropriateness to all types of outpatients. The symptoms or social disturbance scale would appear to rank high on both these points. Presenting symptoms, often the stimulus for self or family referral to clinic, are directly

TABLE 9

Per cent distribution of treated patients by number of levels of movement, by initial impairment and area of functioning

Area of functioning and level of impairment	Total number of patients *	Improved			Unchanged	Deteriorated		
		3 levels	2 levels	1 level		1 level	2 levels	3 levels
Symptoms or social disturbance total	314	4.8	15.3	38.5	30.6	8.9	1.9	0.0
None	29				58.6	24.1	17.2	0.0
Mild	115			39.1	45.2	14.8	0.9	—
Moderate	126		27.0	54.0	15.9	3.2		
Severe	44	34.1	31.8	18.2	15.9			
Occupation (or school) total	314	8.0	5.7	28.0	49.7	5.1	2.5	1.0
Unaffected	130				87.7	8.5	1.5	2.3
Working with difficulty	119			69.7	23.5	1.7	5.0	—
Work severely affected	22		68.2	18.2	0.0	13.6		
Unable to work	43	58.1	7.0	2.3	32.6			
Social (or marital) relations total	314		5.1	28.0	58.6	7.3	1.0	—
Unaffected	148				87.9	10.1	2.0	—
Moderately disturbed	123			60.2	33.3	6.5		
Severely disturbed	43		37.2	32.6	30.2			

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

TABLE 10

Change in mean level of impairment between initial and second ratings for treated patients who improved, deteriorated, or remained unchanged, by area of functioning

Item	Symptoms or social disturbance			Occupation (or school)			Social (or marital) relations		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Total number of patients*	314	120	194	314	120	194	314	120	194
<i>Patients who improved:</i>									
Number	184	71	113	181	52	79	104	35	69
(Initial) mean level impaired (potential improvement)	1.96	2.03	1.91	1.59	1.71	1.51	1.93	1.97	1.91
(Second) mean level impaired	.53	.45	.58	.07	.04	.09	.20	.21	.20
Mean levels improved	1.43	1.58	1.33	1.52	1.67	1.42	1.73	1.76	1.71
Per cent of potential improvement	73.0	77.8	69.6	95.6	97.7	94.0	89.6	89.3	89.5
<i>Patients who deteriorated:</i>									
Number	34	14	20	27	12	15	26	12	14
(Initial) mean level impaired	.76	.79	.75	.52	.67	.40	.46	.62	.32
Potential deterioration	2.24	2.21	2.25	2.48	2.33	2.60	2.54	2.38	2.68
(Second) mean level impaired	1.94	2.00	1.90	2.03	2.08	2.00	2.13	2.12	2.14
Mean levels deteriorated	1.18	1.21	1.15	1.51	1.41	1.60	1.67	1.50	1.82
Per cent of potential deterioration	52.6	54.8	51.3	59.5	59.1	61.5	65.8	63.0	67.9
<i>Patients unchanged:</i>									
Number	96	35	61	156	56	100	184	73	111
(Initial and second) mean level impaired	1.18	1.23	1.15	.45	.54	.40	.55	.51	.57

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

related to the clinic process of diagnosis, disposition, and therapy. That symptom formation is the single most important variable has been pointed out by Srole (14), Pratten (12), and Blum (5). In addition, every individual is subject to such impairment.

Although problems in social (or marital) relations and in occupation (or school) may be the reason for self or community

referral for care, these areas are more tangential to or sequelae to the disorder rather than part of the disorder per se. Also, as Srole indicates (14), they may be "contaminated" with cultural factors.

These scales are inappropriate to certain patients; i.e., for social relations, to very young infants; and for occupation or school performance, to pre-school and retired persons, accounting for some of the

TABLE 11

Mean level of impairment at initial and second ratings and mean levels of movement between ratings, by area of functioning, all treated patients

Item	Total	Male	Female
Number of patients*	314	120	194
Symptoms or social disturbance			
Mean level of impairment			
Initial rating	1.59	1.65	1.55
Second rating	0.88	0.86	0.90
Mean levels of movement			
Improved	+0.83	+0.93	+0.77
Deteriorated	-0.13	-0.14	-0.12
Net gain	+0.71	+0.79	+0.65
Occupation (or school)			
Mean level of impairment			
Initial rating	0.93	1.06	0.85
Second rating	0.43	0.48	0.40
Mean levels of movement			
Improved	+0.63	+0.72	+0.58
Deteriorated	-0.13	-0.14	-0.12
Net gain	+0.50	+0.58	+0.45
Social (or marital) relations			
Mean level of impairment			
Initial rating	1.00	0.95	1.03
Second rating	0.56	0.59	0.55
Mean levels of movement			
Improved	+0.57	+0.51	+0.61
Deteriorated	-0.13	-0.15	-0.13
Net gain	+0.44	+0.36	+0.48

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

"not stated" ratings. In such cases provision should be made for rating "inapplicable." Despite these limitations, these

functional areas are important and add dimension to the appraisal of mental health status.

Interrelationship of scales. The three scales are intended to be mutually exclusive; that is, they measure different aspects of the patient. On a conceptual basis this assumption seems reasonable. As pointed out above, the symptoms scale measures those manifestations most central to the disorder itself. The other two scales, then, cover between them the patient's relationship to the two major divisions of society—the economic and the social.

It is also assumed that the three ratings are actually independent; that is, the rater

TABLE 12

Net gain as a per cent of initial mean level of impairment, by area of functioning, and total for three areas, all treated patients

Item	Total	Male	Female
Number of patients*	314	120	194
Symptoms or social disturbance			
Initial mean level	1.59	1.65	1.55
Net gain as per cent of initial level	44.7	47.9	41.9
Occupation (or school)			
Initial mean level	0.93	1.06	0.85
Net gain as per cent of initial level	53.8	54.7	52.9
Social (or marital) relations			
Initial mean level	1.00	0.95	1.03
Net gain as per cent of initial level	44.0	37.9	46.6
Total for 3 areas of functioning			
Initial mean level	3.52	3.66	3.43
Net gain as per cent of initial level	46.9	47.3	46.1

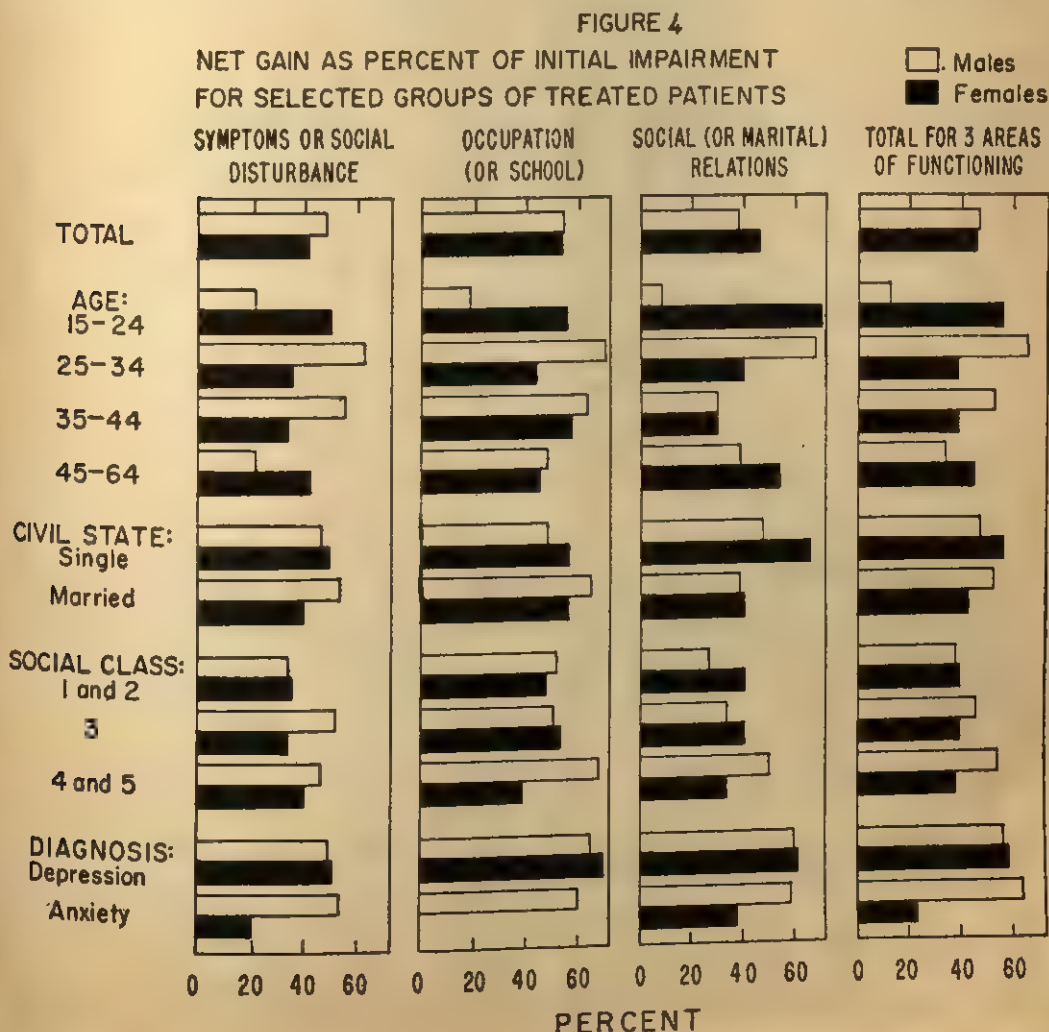
* Excludes 24 patients without initial and second ratings in all three areas of functioning.

is not influenced in his rating of work performance by his rating of symptom impairment. But the rating in each area of necessity takes into account the interaction effect of the presence of impairment in one area on the functioning in another. This interaction, which is operating in the patient's observed behavior, cannot be measured separately.

While some correlation in degree of impairment in the three areas is to be expected, none of the intercorrelations ac-

count for as much as one-third of the variance between the distributions. Thus, over two-thirds of the variance could be attributed to true differences between what is being measured by any two of the scales. The highest correlation between any two of the scales was .53 between symptoms and occupation for females. Other correlations were .38 or less.

Comparability and validity. Problems of standardization of scales for different types of patients can affect intergroup com-



parisons. For example, does the symptom rating constitute a single standard of mani-

festation (e.g., mild apprehension), regardless of disorder, or separate standards for

TABLE 13

Mean level of impairment at initial and second rating by area of functioning and total for three areas, for selected groups of treated patients

Selected groups	Number of patients	Symptoms or social disturbance		Occupation (or school)		Social (or marital) relations		Total for 3 areas of functioning	
		Initial rating	Second rating	Initial rating	Second rating	Initial rating	Second rating	Initial rating	Second rating
Total: Male and females	314	1.59	0.88	0.93	0.43	1.00	0.56	3.52	1.87
Males:									
Total	120	1.65	0.86	1.06	0.48	0.95	0.59	3.66	1.93
Age: 15-24 years	15	1.60	1.40	0.67	0.54	1.30	1.20	3.57	3.14
25-34 "	28	1.64	0.61	0.96	0.29	1.18	0.38	3.78	1.28
35-44 "	41	1.63	0.71	1.07	0.39	0.73	0.51	3.43	1.61
45-64 "	23	1.57	1.22	1.26	0.65	0.91	0.59	3.74	2.46
Civil state:									
Single	36	1.69	0.89	0.97	0.50	1.04	0.54	3.70	1.93
Married	70	1.64	0.76	1.14	0.41	0.88	0.54	3.66	1.71
Social class:									
1 and 2	25	1.60	1.04	0.84	0.40	0.66	0.48	3.10	1.92
3	54	1.69	0.81	1.07	0.52	1.00	0.67	3.76	2.00
4 and 5	24	1.75	0.92	1.33	0.42	1.00	0.50	4.08	1.84
Diagnosis:									
Depression	48	1.58	0.81	1.42	0.50	0.78	0.31	3.78	1.62
Anxiety	31	1.74	0.81	1.06	0.42	1.06	0.44	3.86	1.67
Females:									
Total	194	1.55	0.90	0.85	0.40	1.03	0.55	3.43	1.85
Age: 15-24 years	24	1.58	0.79	0.92	0.42	0.88	0.25	3.38	1.46
25-34 "	48	1.48	0.94	0.52	0.29	1.16	0.69	3.16	1.92
35-44 "	58	1.56	1.03	0.79	0.33	1.03	0.72	3.38	2.08
45-64 "	43	1.51	0.86	1.14	0.63	0.84	0.38	3.49	1.87
Civil state:									
Single	40	1.78	0.88	1.23	0.53	1.31	0.45	4.32	1.86
Married	130	1.54	0.92	0.72	0.32	0.96	0.58	3.22	1.82
Social class:									
1 and 2	37	1.38	0.89	0.73	0.38	1.18	0.69	3.29	1.96
3	65	1.55	1.03	0.72	0.34	1.06	0.62	3.33	1.99
4 and 5	36	1.72	1.03	1.08	0.67	0.63	0.42	3.43	2.12
Diagnosis:									
Depression	108	1.68	0.82	1.06	0.32	0.97	0.38	3.71	1.52
Anxiety	47	1.43	1.13	0.60	0.60	1.12	0.70	3.15	2.43

each disorder (e.g., mild psychoneurosis or mild psychosis)?

If the former, a mild case of a severe disorder (e.g. psychosis) is equated with a severe case of mild disorder (e.g. situational reaction) and potentiality for change for different disorders cannot be compared. If the latter, our summarization of impairment across diagnostic lines is unwarranted. Perhaps both a scale of standardized measure of disturbance and a scale related to the particular disorder are needed.

The distinction between those who are employed and those who work for themselves (see above) hampers comparability on the occupation scale. Role differences as between a housewife and a gainfully employed woman or laborer may account for the higher proportion of men, particularly those over 65, who are unable to work, or with occupational impairment not stated, and the higher proportion of women in the middle range of the impairment scale.

Also, the individual's social role determines the kind and amount of interpersonal relations at risk of impairment. Thus, a person living alone may seem unimpaired in social relations but be unable to live harmoniously with others. Identification of both the general work role being rated (employed, housewife, student, retired) and of the household or living arrangements would be helpful.

Any inconsistencies or nonuniformity with regard to interpretation will affect validity. Therefore, written instructions containing general orientation of the scales and definitions is desirable. Explicit instructions could be rather brief, like the instructions in the American Psychiatric Association Diagnostic and Statistical Manual, 1959 (6) relating to psychiatric impairment. Perhaps our ratings can be similarly tied to some percentage degree of

impairment, although in our opinion descriptive criteria to supplement the adjective rating would yield greater uniformity in interpretation than percentage impairment criteria, because of the orientation of clinicians.

Specification by the rater of the particular symptoms or problems presented in addition to the impairment ratings would provide data to aid in testing validity and reliability, as well as to refine criteria for the rating categories, or perhaps to construct new ones.

The fact that the degree of impairment is directly related to the disposition made (i.e., those most impaired are referred to a hospital bed, those least impaired are not treated) tends to confirm the validity of the scales and their use. It would be helpful, however, to validate the findings by re-evaluations based on followup after an interval of 6 or 12 months, by comparison with self ratings, and by "objective" criteria obtained through field or community investigations.

Reliability. If the number of raters is large (and their background varied), any tendency of some to rate severely may be offset by the tendency of others to rate mildly. The fact that ratings for 1959 were similar to those for 1960 (Figure 2) would support the belief that the ratings were reliable. (Chi square tests between the distributions for the two years show no significant difference.) Nevertheless, in order to test reliability, repeated ratings should be obtained from different physicians on the same patient at essentially the same time.

There may be some tendency to rate less severely after treatment because of the therapist's wish that his efforts be successful. Any such difference in (unconscious) criteria would introduce systematic bias, although the removal of the initial rating

from the case folder may have prevented such upgrading. Such tendencies could be tested through experimental situations, such as comparison of psychiatrist A's ratings of his own patient with A's ratings on patients of psychiatrist B, or with B's ratings on A's patients.

Spacing and number of intervals and boundaries. In the analysis of data, such as in computation of mean levels of impairment and addition of ratings from different areas to obtain a total impairment score, equidistant intervals on three linear scales of functioning are assumed. However, there may be some question as to whether the distance between "work severely affected" and "unable to work" is as great as that between "work unaffected" and "working with difficulty."

It may be more difficult to progress from severe to moderate symptoms than from moderate to mild symptoms or to progress from severe to moderate in some other area. For example, we do not know whether ratings of "severe" measure the same degree of relative impairment for the different areas. The determinations of the upper boundary of impairment may be more difficult for some areas than for others. Further study of these aspects is desirable. Perhaps some light on the subject is provided by the findings themselves.

It would facilitate comparisons between areas if each area had the same number of intervals or degrees of impairment. In addition, a five-point scale might be considered. This would provide more precise information on what is actually a continuum of impairment and facilitate application of statistical techniques. By offering the rater more choice, it may add to the general reliability of the scales. However, perhaps differentiation to this extent cannot be made by the clinician.

Over-all rating. The sum of the levels of

impairment in the three areas provides a total impairment score which, in turn, can be characterized as mild, moderate, severe. The question of weighting each scale in constructing an over-all impairment score should be further considered. Here we weighted each scale equally, regardless of the number of steps it had; thus, severe impairment in symptoms (a four-point scale) and in social relations (a three-point scale) are both weighted three. It would seem, however, that each scale could, on empirical grounds, be assigned different weights to indicate its contribution to the assessment of total impairment.

A comparison of the over-all score before and after treatment helps to summarize change and is particularly useful for individuals who improve in some areas and deteriorate in others. Thus, we can say (from Figure 3) that 69 per cent improved in general. Further specification of criteria for "general improvement" may be necessary, however, since severe deterioration in one area perhaps cannot be offset by gains in other areas. It would be desirable, also, to compare any over-all ratings of improvement constructed by this method with an over-all rating of improved as judged by the therapist, the patient, and by follow-up studies.

Other assumptions. It is implied, but should be clearly specified, that impairment relates to the individual's mental disorder. In many instances this relation may be only one of association rather than causation. Furthermore, caution must be exercised in grading impairment since, as Lemkau has pointed out (8), "unable to work" may be related more to economic depression, or seasonal factors related to the occupation, rather than to a personality defect. Of course, when such external factors appear to be the central problem, the

patient should not be rated psychiatrically impaired.

Another implication is that reduction in impairment between the time of original consultation and termination of treatment is due to the treatment. However, environmental factors, spontaneous recovery, and other conditions may be the primary cause of change. Comparison with a nontreated control group would be necessary to determine the separate effects of treatment and of other factors. Nevertheless, even if control groups are not feasible, information on degree of change accompanying treatment is useful. Data on the amount and type of treatment would assist in the appraisal of change.

The second rating was made either upon discharge or three months after initiation of treatment, whichever date was earlier. Three months was chosen because clinical experience has shown that patients who improve will usually have achieved this gain within three months. Thus, for some patients the second rating represents an appraisal upon termination of treatment; for others, an assessment during the treatment process. Distinction between these two rating conditions should be made in future analyses.

Usefulness. We believe that the scales are fairly simple and pragmatic. Since rating takes very little time, it is feasible for routine reporting. The method is applicable to all types of clinics. It can also be used in situations where the initial and second raters are different persons, provided that assignment of raters is random with respect to this time factor and to patient characteristics.

One of the most useful features, if the conditions of equidistant intervals and additivity can be met, is the quantitative manipulation of the ratings. A number of analyses can be made for each scale

separately, in combination, or on a total score basis (see Appendix). Data reduction and analyses can be readily programmed for routine output on electric accounting and computing machines.

The before and after ratings provide a less subjective basis for judging improvement than when a rater is merely asked to classify improved or unimproved (as in the United States clinic reporting method) both because the ratings are independent of each other and because they furnish some measurable criteria. Wurstter (16) points out, for example, when comparing before and after ratings of psychiatric impairment on the American Psychiatric Association scale with the overall judgmental rating of improvement, that raters tend to classify patients as "unchanged" when in fact they deteriorated.

In addition, the United States instructions "report improvement if there has been any gain in the patient's condition" does not consider the situation of gain in some areas and deterioration in others. And perhaps most important, lack of an evaluation about the patient's degree of initial impairment is a serious handicap to the interpretation of the direction and amount of change.

In summary, the scales provide a considerable amount of useful information about the patient's condition and his life adjustment. As pointed out by Jahoda (7), Blum (5), and others, studies of the interrelationship between impairment criteria, the psychiatric disorders, specific disturbances and other patient characteristics, are urgent research needs. In addition, more precise data on the reduction in disability accompanying treatment programs is essential for evaluation of such programs. Replication of this study in other clinics is suggested.

APPENDIX

Method of analysis of the scales. Patients are distributed according to their initial and second ratings in each of the three functional areas (Tables 1 and 4) and according to their ratings in combinations of areas; e.g., severe impairment in one area, two areas, or three areas (Tables 2 and 5). On the assumption of additivity, a total impairment score is obtained by summing the levels of impairment for the three areas (Figure 1). The mean impairment provides a summary measure which can be expressed as a percentage of total possible impairment (Table 3) and which facilitates intra- and inter-group comparisons (Tables 3 and 13 and Figure 2).

The distributions of treated patients by impairment ratings before and after treatment (Tables 4 and 5) show net movement for the group. However, while some progressed, others retrogressed. Furthermore, the upward or downward movement of a patient is limited both by the boundaries of the scale and by the patient's initial rating. Patients initially unimpaired can move only downward; the severely impaired patient has greater potential movement than the moderately impaired. Inter-group comparisons as to change should reflect, therefore, the impairment of each group to begin with.

To assist in these analyses, for each functional area, a "transition" table was prepared distributing individuals by column, according to initial rating, and by row, according to second rating (Appendix Tables 2-4). The matrix diagonal represents individuals whose initial rating is unchanged. Persons enumerated above the diagonal have a more favorable second rating; those below the diagonal have a more favorable initial rating.

From these "transition" tables and by

data reduction methods, the following exploratory summaries were made:

1. The number of persons who improved, deteriorated, or remained unchanged (Table 6).

2. The movement of individuals in all three areas simultaneously to show whether the person improved in one area but deteriorated in another (Table 7).

3. The distribution of patients by the number of levels of improvement and deterioration in total impairment score (Figure 3).

4. The movement of patients who were at "risk" of improving or deteriorating, and those who could change in one direction only (Table 8).

5. The direction and amount of change in individuals by initial rating (Table 9).

6. The mean improvement as a percent of the maximum possible improvement for those who *improve*. The mean deterioration as a per cent of the maximum possible deterioration for those who *deteriorate*. (Table 10).

7. The mean improvement (or gain) and the mean deterioration (or loss) for the total group (Table 11).

8. The net gain for the group as a percent of the group's initial impairment (Table 12 and Figure 4).

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APPENDIX TABLE 2

Work table showing distribution of treated patients by initial and second ratings of impairment, symptoms or social disturbance

	Level	Initial rating				Marginal totals (second rating)
		None	Mild	Moderate	Severe	
Second rating	None	17	45	34	15	111
	Mild	7	52	68	14	141
	Moderate	5	17	20	8	50
	Severe	0	1	4	7	12
Marginal totals (initial rating)		29	115	126	44	314*

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

APPENDIX TABLE 3

Work table showing distribution of treated patients by initial and second ratings of impairment, occupation (or school)

		Initial rating				Marginal totals (second rating)
		Unaffected	Working with difficulty	Work severely affected	Unable to work	
Second rating	Unaffected	114	83	15	25	237
	Working with difficulty	11	28	4	3	46
	Work severely affected	2	2	0	1	5
	Unable to work	3	6	3	14	26
Marginal totals (initial rating)		130	119	22	43	Grand total 314*

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

APPENDIX TABLE 4

Work table showing distribution of treated patients by initial and second ratings of impairment, social (or marital) relations

	Level	Initial rating			Marginal totals (second rating)
		Unaffected	Moderately disturbed	Severely disturbed	
Second rating	Unaffected	130	74	16	220
	Moderately disturbed	15	41	14	70
	Severely disturbed	3	8	13	24
	Marginal totals (initial rating)	148	123	43	314*

* Excludes 24 patients without initial and second ratings in all three areas of functioning.

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"In our innermost soul we are children and remain so for the rest of our lives."—Sigmund Freud

Pets: A special technique in child psychotherapy

The use of a pet, a living tool, brings in new dimensions in child psychotherapy which, of necessity, must help crystallize new concepts and new ideas. Many child therapists accidentally discover that a pet is a valuable aid in child psychotherapy. However, their general impression is that while the pet is useful, he certainly is not a crucial factor in treatment.

I, however, believe that in certain case situations, pets *must* become a part of the treatment plan. I wish to reiterate a point made by so many mental hygienists that we have too many disturbed children and too few psychotherapists. Furthermore, treatment takes an interminably long time, and short cut is necessary. I believe that in many cases the use of pets in psychotherapy offers this short cut.

My experience with pets made me reject, very reluctantly, the maxim that if a child talks and develops "insight," healing occurs, or that if a child discusses his day in

great detail, we have been successful in penetrating his inner defenses. I feel that something very significant may occur even though the child merely plays with the pet and does not utter a word throughout the hour. Appearances are very often deceiving. In therapy, things are very often not what they seem to be. Healing does not always occur where one would think it should . . . and it sometimes does occur in the most unexpected places.

I prefer the term "pet therapy" rather than "play therapy." The term "play therapy" is really a misnomer. The word "play" connotes a self-chosen activity which is largely absent in the structured setting of a

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clinic or a private therapist's office, where the purpose of the activities are predetermined, the time set beforehand, etc. What we are actually doing in play therapy is engaging in directed make-believe.

There are two interrelated aspects of pet therapy. One, the pet's use as a therapy aid by the clinician in his office. The other, as aid to therapy; i.e., the directed introduction of the pet into a child's home.

Adults ascribe human attributes to animals; children reverse the process and attribute animal qualities to human beings. Contrary to the widely held impression, it is, in my opinion, easier for a child to identify with a human being than with an animal. However, it is even more difficult for a child to project life into and identify with an inanimate object. The great virtue of pet therapy is that it permits identification on this intermediate level. Further, experienced child therapists know that dolls, clay, finger paints and other appurtenances of the play room cannot be truly loved. They are not alive; they do not grow, digest, respond. The child intuitively feels that they cannot share his feelings with him. Unlike his reaction to a doll, a child can conceive of the pet as being part of himself, part of his family who goes through the same experiences he does.

It is well-known that through play a child may rehearse and try to resolve some of his life's problems. A sensitive therapist can utilize the child's play with the pet to understand the child. This understanding of what the child is trying to convey strengthens his relationship with the child. Taking walks helps to offer motor release to some children. The pet can also help solve the problem of sharing, separation, and formulation of self-image.

In his use of pets a child goes through a maturational process. A pet that is adequate at one time may no longer be accept-

able or useful at another. The differential meaning of a pet to a child thus has to be considered very carefully. There is a certain lawfulness within which pet therapy operates. There is a change in themes, not only in terms of the psychodynamics of the situation, but also in terms of the length of time the child spends in therapy.

In the beginning the child just pets or talks to the animal and engages him in imaginative play in which the pet does not participate at all but merely submits to being handled at the whim of the child. The child at this point disregards the therapist entirely.

In the next stage, the pet is the center of the child's fantasied activity and is made by the child to participate in the role assigned to him. The therapist is permitted to be of auxiliary service. After a while, the child begins to people his fantasied make-believe world with other activities in which the pet, while actively participating, plays a role subsidiary to that of the therapist. Finally, the pet is no longer needed in the therapeutic interchange.

It is often first necessary for infantilized children and those with behavior disorders to gratify some of their needs before an attempt may even be made to approach their nuclear conflicts. A child who has been sadly deprived of love may find it most difficult to accept affection from an adult, but he is capable of receiving affection from a pet. In the child's relationship with the pet, we may see a reflection of the way he was treated at home. Eating with the pet and therapist, singing and dancing with the pet, etc., may satisfy the child and yet help develop a relationship with the therapist. I find that only after some children establish a relationship with a pet do they begin to relate to me.

I believe that "pet therapy" is specifically useful for the nonverbal, severely ego-dis-

turbed child. It is well-known that most children learn about the world and the differences between self and nonself through the medium of their body. This is particularly true for the autistic child, whose contact with reality is most tenuous. A pet would serve to strengthen such a child's cathexis and would help him become aware of the cause and effect relationships.

It seems to me that if we trained pets to give bodily comfort to the autistic child in his crib or while he is a toddler and thus provided constant stimulation throughout his waking hours, it would assuage the autistic child's all-consuming anxiety and help him to establish a firmer grip on reality. Thus, while on the average, a child is seen in therapy only twice weekly, the pet can exert his healing influence on the child 24 hours a day. We will find that pet therapy will affect the very substratum of the child's emotions and his unconscious concept of self as being a desirable person. The therapist no longer would have to handle in toto the basic affectional needs and thus could work on a higher conceptual level.

Another implication of the use of pets, since they are so active, is that the main locus of therapy need no longer be in the playroom, but in the wider world in which the child has to function eventually—in the street or play ground or wherever the child's and his pet's fancy take them.

The effectiveness with which a child therapist utilizes pets will greatly depend upon his previous experience with pets, how comfortable he feels with them, his personality traits, and his philosophy of treatment. It is to be noted that some child psychotherapists feel uncomfortable when they no longer are able to offer facile interpretations and to interact on an intellectual level with the child. Another relevant factor is that a pet, unlike finger paints or a puppet, must

be taken care of. He is alive, requires active care, compels attention, must be fed, medicated, exercised and loved.

Each pet has his own behavioral characteristics and moods which must be considered. For example, if one wishes to secure a dog as a psychotherapeutic aide, the immediate question is what kind of a dog to choose, since it is well-known that different dogs vary in their temperamental characteristics.

The pet chosen as therapy aid must appeal to the child and meet the psychodynamics of the case. It seems to me, on the basis of my experience, that children who have difficulties in relating socially to their peers prefer large animals; those whose difficulties are mainly intrapsychic prefer small animals.

Quite frequently the cat is preferred by some children who are undergoing an oedipal conflict and are resentful of authority. Young withdrawn children who are not yet ready or wish to enter into an "entangling" emotional relationship also seem to prefer the cat. These children are emotionally "burned," resent authority and being pushed; they therefore prefer a pet which is unobstrusive, independent, not demonstrative in its affection, and does not initiate or seek a friendship.

I have also found the manner in which children approach a pet to be of diagnostic importance. The child's approach to the pet, his attitude and behavior may give me many clues to the child's conflicts. Thus, the aquarium is a potent projective device for some children. Their looking at the fish is somewhat akin to one's looking at the fireplace. They watch the antics of the fish and weave many a fantasy which may later be acted out in the playroom.

To illustrate: I noticed that Richard, age nine, a new patient, was sitting in the waiting room with his back toward his

mother and the aquarium and alternately opening and closing his mouth as if imitating the oral play of the fish. I took some fish food and motioned to Richard to help me. Like any other child therapist, I try to establish contact with a child whenever and wherever I can reach him.

Richard reluctantly accepted this assignment: I put the food in his hand and let him drop it in the aquarium. The child seemed concerned and perplexed when he noticed the lively competition for food among the fish. I casually remarked that the big fish do not devour the small fish but that they all live amicably in the aquarium but compete for the available food.

The next few sessions were devoted to the observation of the fish and a discussion of their names and habits. Richard's primitive fear of being devoured was thus a little assuaged; and some boundaries were established between what the fish seemed to be and the reality of their existence. Richard then wished to learn how to start an aquarium of his own. This was the crucial point in my relationship with him.

My philosophy of treatment is that since most of the child's difficulties originate in the home environment, this is where they have to be resolved. It is to be noted that throughout recorded history, the value of pets to children seems to have been particularly significant. Innumerable accounts of the beneficial relation between pets and children may be found described in the literature of almost every nation. It sometimes seems, when we peruse these accounts, that these relationships between pet and child are almost symbiotic in nature.

It is also a fact, attested to by many generations of parents, that when a pet dies, their child is affected almost as strongly as if a member of the family passed away. Yet, although most people have had a pet at one

time or another, few have stopped to examine what the pet meant to them and still fewer scientists have considered the psychological significance of the pet to the child.

When a family accepts a pet, a subtle change begins to occur in the family's dynamics, in its very subculture. There occurs a dilution in a family's interaction and a reconstruction of the family's psychological potential. It seems to bring about a certain attenuation of the symbiotic relationship between mother and child and a redirection of these emotions toward the pet. This may be particularly true of the small family.

The discussion of the pet's antics is a subject in which all members of the family may participate. The mere discussion of what the child can do for the pet forces the child to turn his thoughts outwardly, and to think of himself in relation to his parents and his pet. The child may thus learn that he, too, like his parents, has to undergo many inconveniences for the sake of the loved one. He further learns that sharing a loved object, a pet, does not mean losing it or that the loved object loves one less merely because it also offers its love to others. The pet acts like a lightning rod, diverting the pressure on the child. After the child learns about the peculiarities of his pet, he can use him more constructively in his fantasy.

The following case, illustrating the use of pets in psychotherapy, is merely suggestive. The discussion of therapy sessions has, of necessity, been telescoped. Case data had to be changed to avoid any possibility of identification.

Miriam Lev, age eight, was referred for treatment by a day [Yeshiva] school she was attending, because she was a regular "tomboy;" her work was below her potential; she was abusive to teachers; she started frequent fights with boys; and yet she would

burst into tears very easily. Mr. Lev was very reluctant to follow up on the school's recommendations as he thought that Miriam was merely lazy and too noisy. However, he had no alternative since the school threatened to expel the child. Mrs. Lev, on the other hand, felt that the school was justified in the referral. She thought that Miriam was stupid, constantly fought with other children, was disobedient, had no friends, and had frequent nightmares.

Mr. Lev was an extremely pious man who had arrived penniless in this country. He had managed, by dint of very hard work and clever business deals, to become moderately wealthy. He had lost his entire family in concentration camps. At age 50, he remarried. Mr. Lev was unhappy over the fact that his wife was "too young looking," was "too attractive and sexy," was a poor housewife and was unable to manage Miriam. He would constantly compare Miriam unfavorably with his sons who perished. Mrs. Lev admired and loved her husband. She was most unhappy that she could not produce what her husband wanted most, a boy. (Miriam was a "Caesarean baby" and Mrs. Lev could not have any more children). She felt inadequate, both as a wife, and as a mother and for the sake of family peace she did not support Miriam.

At the office, Miriam brightened visibly when she saw my dog. She confided that she had nightmares in which ghosts tried to kidnap and kill her because of her "sins." Her imaginary companion, David, tries to help her to chase the ghosts away, but to no avail. She then runs to her parents' bedroom, much to her father's displeasure. Miriam further told me that she always wanted to have a dog, but that her parents would not hear of it.

It later transpired that Mr. Lev felt that it was not proper for an Orthodox Jewish

child to play with a dog. Miriam played with the dog at the office and took him for walks. It was her act of defiance. She felt that the dog was the long-prayed-for friend who was in league with her against her parents. The dog thus provided Miriam with a tolerated identification with an aggressive animal which supported her against the dangers which threatened her.

My impression that Miriam would benefit from having a dog of her own was discussed with her parents. I indicated that no prior agreement with Miriam for the care of the dog was to be a prerequisite. I felt that eventually she, on her own, would accept such responsibility. Initially, it seemed to me, it was unwise to burden an emotionally disturbed child with unwanted responsibilities for the pet, such as walking, feeding or combing him. I feel that at the beginning a pet should be enjoyed and not become another superego threat. I suggested that the Levs permit Miriam to assert her autonomy and that she be given the right to make provision for the dog. The dog was to stay in her room. She could rearrange her furniture to make the dog more comfortable and she was even to be permitted to sleep with the dog, if she wished to. Since this was a doctor's prescription, Mr. Lev reluctantly agreed to secure a dog.

May I add that a trying period followed for the dog, Miriam and her parents. The dog made a hole in a chair, chewed the family's best shoes, and had many accidents. Many a time Mr. Lev wished to get rid of the dog, but he met the opposition of both Mrs. L. and Miriam. Mrs. Lev constantly fussed over the dog. At one time when she brought him to the office, the dog had diarrhea and Mrs. Lev wiped him.

Miriam noted that the dog was loved, no matter what he did. She learned that she too might be "bad," rebellious and imperti-

nent, and still be loved. She learned to accept her own "badness" and to feel that she could still be acceptable and loved. This realization that one may be doing "naughty" things at times and yet be loved, I feel, was the crucial point in Miriam's treatment.

SUMMARY AND CONCLUSIONS

I believe that pets may be useful in two ways: first, as psychotherapeutic aids; i.e., as catalytic agents helpful in speeding up therapy in the therapist's office; and second, as aids in psychotherapy; i.e., being placed in homes of emotionally disturbed children where they tend to restore a healthy communication between members of a family.

Pets are useful not only in homes whose emotional climate seems to promote dissension and poor mental hygiene, but also in the average home, where they may serve to promote positive mental health. Pets should be the *sine qua non* of any institution, and general or mental hospital. The aseptic environment of such institutions would disappear and the mothering contact and sensory stimulation offered by pets would tend to go toward overcoming their deficiencies.

Questions arise: What is the meaning of the pet to the child? How does the process of emotional healing occur? We do find that psychoanalysts and psychologists have done quite a bit of work in analyzing the

meaning of animal symbols in dreams, etc. However, comparatively little work has been done and hardly anything is known regarding the meaning of an animal pet to a child, or what role a pet plays in child therapy.

Do we possibly have in pet therapy a tool which permits us to examine at great length and under magnification the elusive something which occurs in child therapy and promotes emotional healing? I believe that we do. However, it is not possible for us, with our limited clinical facilities, to give a more positive answer. What we now need is a clearing house and possibly a journal devoted to the exchange of experiences and research findings on the use of pets as therapy aids and aids in therapy. The research possibilities are limitless. What about the use, on an experimental basis, of all kinds of pets? This would help to establish and explore for each animal the parameters that affect the child's recovery. Thus, we may be able to arrive more rapidly at an effective methodology in the study of pets as psychotherapeutic aids. This will enable us to learn the most effective methods of pet selection, what pets are most useful and when and how they are to be trained.

In conclusion, I feel that the success I had in using pets in therapy has wider mental hygiene implications, which we cannot afford to overlook.

Technical alterations in the psychotherapy with an adolescent cerebral palsy patient

Within the last decade the practice of psychotherapy has broadened in spectrum and has become sufficiently eclectic to be useful with mentally retarded children, character disorders, sex offenders, stutterers and a variety of other classifications (5). With broader application, specialized techniques have been developed.

The purpose of this paper is to add to the continuing effort to develop clinical skills for working with people who are typically considered "poor psychotherapeutic risks." Specifically, the short-term psychotherapy of a 14-year-old cerebral palsy patient will be described with particular emphasis upon obstacles to treatment and the technical alterations which were developed to overcome these obstacles.

THEORETICAL CONSIDERATIONS

Much has been written about the effects of physical handicap upon the ego and the subsequent adjustment of the handicapped

youngster (1, 2, 4, 6, 7, 11, 12, 13). There is little doubt expressed in the literature that the severe physical handicap of a child carries with it, as one of the side effects, some degree of ego impairment. Psychoanalytic theory places special importance on the physical self, both in differentiating the self from others and in the development of the ego.

"In the development of reality, the conception of one's own body plays a very special role. At first there is only the perception of tension; that is, of an 'inside something.' Later, with the awareness that an object exists to quiet this tension, we have an 'outside something'. One's own body is both at the same time. Due to the simultaneous occurrence of both outer tactile and inner sensory data, one's own body becomes something apart from the rest of the world and thus discerning of self from nonself is made possible. The sum of the mental representations of the body and its organs, the so-called body image,

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constitutes the idea of *I* and is of basic importance for further formation of the ego (8, pp. 35 and 36).

Other noted psychologists have commented on the importance of physical self for personality development from different theoretical frames of reference (9, 10, 14). However, Wright cautions theoreticians against presupposing a straight-line correlation between physical handicap and emotional disturbance during adolescence. "Although physique carries a particularly heavy emotional loading during adolescence, it is not correct to conclude that any single physical deviation will invariably or even probably produce distress (14, p. 181).

Ausubel adds: "The psychological consequences of deviation will depend on 'social and individual attitudes toward nonconformity,' the strength of intrinsic attitudes of self-acceptance and the possession of compensatory assets" (3, p. 102).

In addition to the structural aspects of personality development in physically handicapped children, the writer has noted a number of consistent psychodynamic factors which have had particular applicability in the understanding of adolescent cerebral palsy patients with medium to severe crippling.

The physical and social development of the child with cerebral palsy is slowed down. His motility is impaired. Often he is incontinent until the age of 7 or 8 and sometimes dependent upon urinary bags throughout his life. In addition to toilet training, personal responsibility for cleansing, dressing, eating and speaking often need be postponed. Many of these youngsters are carried over the shoulder of their parents to the period of preadolescence.

Undoubtedly these atypical patterns of development predispose them to severe dependency problems as they get older. Consequently, the adolescent cerebral palsy

patient in psychotherapy will often fight off a dependency relationship with the therapist or succumb to it so readily that there is little potential initiative manifested.

In their psychosexual development a post-oedipal development is an exception. Most of these youngsters remain partially to totally fixated in the oral and anal phases of development. So much attention and energy has had to be given to the functions of eating and eliminating that they often remain the chief avenues of sexual gratification even in adulthood. Genital sexuality is often hampered until these adolescents can work through their feelings regarding extended handling of their sexual organs by their parents during ages where there should be a quiescence in parent-child intimacy. It is worth noting that the prolonged physical dependency of the crippled child upon his parents sometimes makes it necessary for these parents to ignore some of the taboos essential in the normal child-parent relationship.

A number of obstacles to psychotherapeutic treatment with the cerebral palsied youngster follow from the research, theory and clinical observations:

1. Strong dependency needs continue to be buffered by the ever-present palsy.
2. Affliction at birth precludes the opportunity to develop a more favorable self-image.
3. Self-sufficiency with inadequate personal equipment is a feeble alternative to the gratification derived from being cared for in the bathroom, at the dinner table and in the bedroom.
4. The "why should I be the one who is afflicted?" question is one that tends to set off a severe depressive reaction, while the answer is sought.
5. The avenues for sexual growth and exploration are limited by the lack of

motor co-ordination, the rejection by peers of the opposite sex, and the conveyed fears of adults concerning their development in this area.

CASE HISTORY

Bob T was born in 1947. Mrs. T was anemic during the pregnancy. He was delivered after 7½ months of carriage; labor was forced for 2½ hours; toes were bruised; and legs remained in a triangular position for three weeks. The baby breathed spontaneously at birth and weighed 7 pounds 2 ounces. Bob was a healthy baby and was circumcised a few days after birth. He had the usual immunizations at 6 and at 9 months. He was able to finger-feed at one year and spoon feed at two. Head control was established at three months, and he could roll over about the same time. He began to crawl at three years and could stand without support at four years.

At the age of 8½ months Bob was diagnosed as a "congenital spastic." He was placed on a Prostigmine Regime until the age of two. Loss of eyelid droop and muscle tone improvement was noted. At two the standing diagnosis of cerebral palsy with general loss of muscle control in the abdominal and gluteal muscles was established. Bob was fitted for an abdominal corset in 1952 and long leg braces in 1953. He continues to wear these physical aids. Physical therapy case notes have the following repetitive pattern: slight gains, broken appointments, case temporarily inactive, reopened, slight gains, broken appointments, etc.

Bob's father is a self-made man from an Italian-English, Roman Catholic cultural background. He has attended college over the past 10 years and has gained inservice training in the field of metallurgy. Mrs. T is from an English-German, Roman

Catholic background. She has been trained as a commercial artist but is employed full-time in the home caring for her 4 children, of whom Bob is the oldest. Bob, age 14, is followed by a brother, age 13; a sister, age 8; and a brother, age 3.

At the age of 7 Bob was tested with the Stanford-Binet, Form L, and earned a score within the bright normal range of intelligence. He received homebound teaching until the age of 9 when he was placed in a school for handicapped children. At the age of 10 he was transferred to a different school and reacted to the transfer with an episode of soiling his pants two to four times a month. Bob's pediatrician prescribed 10 mg. of Aterax per day to tranquilize the anxiety assumed to be underlying the soiling. Throughout the period of school attendance, Bob was described as being resistant to learning and to the school's physical therapy program.

Bob was referred for psychotherapy because of his underachievement in school and physical therapy, his constant regressions into unrealistic fantasies and general immaturity.

Administration of Treatment

Bob was seen once a week in an outpatient orthopedic clinic. His physical therapy, occupational therapy and social service were enlisted at times as aids to treatment. The therapist was a post-doctoral fellow in the counseling service of Merrill-Palmer supervisors. There were 29 treatment hours with Bob, an equivalent number of supervisory hours, and a total of 5 interviews with Mr. and Mrs. T.

Treatment

The therapist was cautious about working with Mr. and Mrs. T because of their dissatisfaction with previous psychological

contacts. They consented to treatment for Bob but were weary of having people telling them how to rear their children. The goals of therapy were to help Bob understand his passive resistance, "smart aleckiness," and find ways of handling his impulses which would not elicit rejection from others.

A second goal of treatment was to put Bob's fantasies to the test of reality. The initial stages of therapy were devoted to establishing a positive working relationship with the patient.

The therapist initially defined the modes of operation with the patient in too-rigid a manner. He expected a boy of 14 with better than average intelligence to be able to utilize verbal therapy on a time-limited basis. It became apparent that Bob (who emotionally was more like an 8 or 9 year old) could not utilize classical methods of treatment.

The first six interviews were a period of no movement. Bob was not willing to trust or reveal himself to someone who was not going to allow him to function in his typical manner. He was only comfortable when he knew the person he was with and could control the other person with this knowledge. He continually asked the therapist personal questions and would test the boundaries of the therapist's discipline. (The patient would open the therapist's drawers and want to read case notes.)

With the advent of no therapeutic movement, the therapist, with the help of his supervisor, made a number of changes in the mode of operation. Play materials such as clay, crayons and games were offered. At times the entire verbal therapy was carried out during a game of checkers or darts. The time limits of treatment were made more flexible so that the patient could determine if he wished to continue treatment or not.

The therapist would help the patient to help himself through a variety of experiences. One that was particularly meaningful to the patient was grasping his hands, fisherman style, and walking down the stairway with him. This activity elicited some anxiety from the therapist and the patient since both were aware that if either slipped they would tumble down the stairs entangled in 60 pounds of braces.

The therapist made a constant effort to help Bob become more aware of his strengths. Bob has a definite asset which he undervalued. Although crippled, he has definite artistic ability. The therapist began talking with him about how he could use his talented hands. Movement became rapid with the newer modes of operation.

Bob brought in his concerns about having his sexually matured body handled, dressed and cleansed by his mother and young female attendants at school. Fortunately, Mr. and Mrs. T had observed Bob's increased motivation in school and loss of belligerent attitude and now were willing to accept help from the therapist in rearing him. The therapist helped the father to accept more responsibility in caring for Bob at the toilet, shower, and other places where physical contact and exposure were necessary.

Bob began to identify with the therapist strongly and would carry the therapist's program of helping him to help himself into the home. Around the middle phases of therapy the patient began expressing many angry feelings toward his father and mother.

Bob's wish to murder anyone who would put him in a wheelchair (Mr. T threatened Bob with a wheelchair if he did not carry out his physical exercises) was considered seriously by the therapist. The therapist considered with the patient the possibilities

of committing murder within the context of the patient's handicapped motility and lack of finances. Realization of the extent of his handicap elicited the patient's basic feelings of inadequacy. Bob made a plea to sail off to some primitive island where he could live alone.

The therapist considered this plea for alienation again in terms of its possibility. This brought a new surge of hostility from the patient, directed and expressed toward the therapist. Bob believed that as he grew older he would be able to walk without crutches, drive a low-slung sportscar, marry easily, have a family and earn lots of money as a metallurgical engineer. No one had ever delineated for him fact from fantasy and possibility from probability. The therapist worked closely at this point with the orthopedic surgeon, and it was determined that Bob might be able to drive in an especially-equipped car and, from a physical point of view, marriage and sexual relations might be possible. Walking without crutches was pretty much out of the question.

All fantasies that the patient brought in were entertained in terms of their reality value. The patient became very indignant when the therapist called the U.S. Navy recruitment office with him present in order to establish that he could not join the Navy, as he had fantasied.

His unwillingness to accept his crippling was brought to a head during an interview in which Bob and his parents were seen together. The purpose of this interview was to discuss vocational possibilities for Bob. For the first time, during this interview, Mr. T approached Bob with the fact that he could not perform the work of a metallurgical engineer with his handicap. The therapist confronted Bob with the impossibility of his driving a low-slung sportscar. With Bob's anger welling up

inside of him, Mrs. T commented sympathetically, "This is a hard pill for Bob to swallow." It was for her, too.

An alternate modality in which treatment was carried out was psychosexuality. Purposeful sex education assured Bob that he could discuss his concerns in this area during the interview. Gingerly, at first, he revealed strong voyeuristic tendencies and an anal conception of birth. At first he depersonalized his drawings pertaining to sex.

The therapist, utilizing knowledge from early experiences with Bob, extended himself by drawing on paper some of his own conceptions of sexuality. Two essential needs emerged from the psychosexual modality of treatment. The patient tried to use the therapist as a procurer of pornographic material and experiences. In some of his more daring hours Bob demanded that the therapist bring his secretary into the office, make her undress and leave him alone with her. The second need, the desire to be nurtured, was brought into the interview in an interesting manner. Bob became very secretive, demanded confidentiality, then confessed that the reason girls shun him is because he cannot use his hands adequately to cleanse himself after defecation. His rationale for being shunned by girls was understood by the therapist as a powerful defense against rejection, buffered by taking on the characteristics of a buffoon in appearance and behavior to ward off inner sadness and to explain the rejection. This interpretation was confirmed when Bob, attending a camp for crippled children, became interested in a girl and soiled his pants seven times in 48 hours in order to explain a seemingly inexplicable rejection from her.

In spite of his reaction to rejection from girls, gains were noted in a number of

areas. Bob now looks and behaves more like a 13-year-old than a 9- or 10-year-old. He has lost his "smart alecky" attitude. He is responding well in school and physical therapy. There have been some basic revisions in Bob's self-concept. He realizes much more his physical handicap and his vocational assets.

Generally, his fantasy life is filled with more potentially productive ideas. Specific familial conflicts have been resolved because Bob no longer sits back and instigates fights between other family members. He is more able to express both positive and negative feelings toward his father. The remaining problems in the area of Bob's ability to cope with rejection from peers are still handled by soiling.

DISCUSSION

Bob admitted to no dependency needs, although he depends upon another individual in almost every aspect of his life. After reactive, arrogant independence was given up by the patient, the therapist chose to ward off a severe dependency relationship and afford the client with help in helping himself. This alteration served as a buffer against a too-speedy regression and, at the same time, helped to increase the patient's skills in handling day-to-day situations.

The self-image of a palsied child is based upon his accomplishments during childhood. Unfortunately, the child with palsy is handicapped in those skills which are attributed with primary importance during childhood; i.e., walking, talking, bowel and bladder control, feeding, etc. The inadequate self-image can be countered through "foresight therapy." In addition to having the child recall his past experience, the therapist directs the child into fantasies about himself 5, 10 or 15 years henceforth. Some of these fantasies

have proved to be as bizarre as early childhood nightmares.

The fact that "something is wrong with me" is sometimes given to bizarre speculation about how the patient can be "righted" or punished. "Foresight therapy" affords the therapist with the opportunity to correct anxiety-ridden images about the future and to educate the patient on his potential vocational assets.

The difficult problem of how to help the patient part with infantile sexual gratification was encountered in the case illustrated. Although adolescents sense the inappropriateness of having adults of the opposite sex care for them at the toilet and shower when they are sexually mature, the repressed sensual gratification obtained from such care is a powerful deterrent against giving up such experiences. The promise of adult heterosexual relationships is vague for the palsied adolescent. In the case illustrated the therapist did not dwell on the patient's infantile gratifications but instead enlisted the aid of the parents in changing the patient's outlets for sexual gratification. The patient only began to grope for more mature ways of meeting his sexual impulses when father replaced mother as his attendant at the toilet and shower.

The palsied adolescent's question of why should he be the one who is afflicted precludes an intelligible intrapsychic answer since the affliction is not something that the patient wrought. The analogy which might help clarify this answer is that of the brain-damaged adolescent asking the question of why should he be so confused. In both cases their burden is not something they purposely wrought; yet as adults they will be expected to accept responsibility for what they are.

In the case illustrated, the patient was comforted by the therapist pointing out

that everybody has burdens to bear to a greater or lesser degree. Dark skin, lack of money, limited intelligence, cowardliness or marital problems are some of the many burdens people bear. He conveyed to the patient that as he matured he would continue to be judged by some fearful people for his palsy, but the primary criteria for his own worth would be his manner of coping with his palsy.

SUMMARY

The purpose of this paper was to describe psychotherapy with a 14-year-old cerebral palsy patient. Particular emphasis was placed on the obstacles to psychotherapy brought about by the physical affliction and the technical alterations which were used to overcome them.

Theories, research and clinical observations in the field of somatopsychology all point to some degree of ego deficiency in medium to severe crippling from birth. Problems specific to cerebral palsy which have previously precluded psychotherapeutic intervention were (1) the affliction buffering dependency needs, (2) lack of opportunity for development of positive self-image, (3) gratification of pre-oedipal sexual strivings by significant adults, and (4) the seemingly inexplicable rejection of those afflicted.

Technical alterations in psychotherapy were discussed, utilizing a case study to illustrate implementation of technique. The therapist warded off a severe dependency relationship by helping the patient to help himself. Opportunity for developing a positive self-image was afforded by "foresight therapy," a process of exploring and analyzing progressive fantasies in addition to regressive fantasies.

Pre-oedipal sexual strivings were frustrated through manipulation of the familial environment and exposing the

patient to a purposeful program of sex education. Actual rejection and feelings of rejection were handled by helping the patient to use his personal assets effectively and to ward off implied or felt worthlessness.

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Learning mental health consultation history and problems

HISTORICAL ASPECTS

Mental health consultation as a means of helping professional workers of caretaking agencies to function more effectively is a relatively recent development. Papers on consultation to agencies appeared in the literature of the nineteen thirties and, with increasing frequency, in the forties.

The consultant's role in agencies was seen as one of providing technical advice or of educating the workers, as in Goldman's 1940 paper in 1940 (13). Sloane, in 1936 (21), described a method in which the consultant helped untrained social workers to deal with difficult clients by the consultants' retention of case responsibility and concerted efforts to educate the worker to a higher level of functioning.

The first paper which deals with mental health consultation as it is now conceived was written by Jules Coleman in 1947 (12). Coleman's paper on psychiatric consultation in casework agencies stressed the fol-

lowing: (1) The consultant's chief concern is not the worker's case or client but an understanding of why the worker presents this problem now; (2) His object is to discover how the worker needs help and what feelings of the worker need to be understood and dealt with; (3) He also points out that the consultant, unlike the supervisor,

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does not represent the agency and is therefore concerned with the worker and his problems and not with how the case is handled.

In 1950 Susselman (22), in a paper on psychiatric consultation in a probation department, described how the consultant's awareness of the consultee's work problems as internalized conflicts may be used to help the consultee deal with a difficult problem by clearly presenting and discussing with him the dynamically appropriate alternative means of handling these critical problems.

In 1950 Maddux (16), using Coleman's methods, described how relatively untrained public welfare workers could be helped to function more effectively if the consultant understood what caused their anxiety. Problems indigenous to a particular agency—such as problems of handling the dependency of clients in public welfare agencies or specific difficulties of working with people which the worker might have because of lack of training and knowledge or personal problems—all need to be understood as possible contributors to the worker's anxiety.

Maddux saw the consultant's job as relief of worker anxiety by means of ventilation of feelings of anger, hostility, rejection, etc., to a noncritical, nonjudgmental consultant who does not become involved in personal problems but looks at these difficulties as professional problems. He also indicated that he found little need to give direct suggestion or advice, which tended to make the worker dependent. It was interesting to me that I had described similar findings some six years later out of experiences in a variety of agencies (2).

The concept of mental health consultation that comes close to the one most workers find helpful has been best enunciated

by Caplan (8, 10, 11, 19). Although Caplan includes a variety of activities under his category of mental health consultation, his emphasis is on the consultant's understanding of the consultee's troubles as being the result of the worker's intrapsychic conflicts, upon which the client's problems and behavior impinge. The technique of helping the consultee is an indirect one; it uses discussion of the difficulties and problems of the client as a focus for discussion with the consultee. This delimits the problem as a work problem and is a means of relieving anxiety and helping the consultee resolve similar problems of his own.

Out of many different settings and experiences in the last 10 to 12 years, a number of workers have contributed from their own work to refinement and expansion of the specialized techniques known as mental health consultation (1, 3, 4, 6, 7, 17, 20).

OPPORTUNITIES FOR TRAINING

Several formal centers for training have developed. The pioneering effort by Gerald Caplan at the Harvard School of Public Health has been a great stimulus to mental health consultation throughout the country since the training program has also provided opportunities to test hypotheses and to further research work. Viola Bernard at Columbia University's School of Public Health has developed a curriculum geared to training psychiatrists in community psychiatry, one phase of which is supervised training in consultation.

In the last two years Portia Hume has directed a new Center for Training in Community Psychiatry under the auspices of the California Department of Mental Hygiene in Berkeley. Here also there is heavy emphasis on seminars and supervised training in mental health consulta-

tion. Several training programs in general psychiatry and in child psychiatry are including some orientation and training in mental health consultation. Many agencies are now conducting inservice training programs in consultation (9, 14, 23).

Efforts over the last 12 years to teach mental health consultation to social workers and psychologists in two school systems and to child psychiatrists in training have made me aware of some repetitive obstacles to the learning of mental health consultation that require special attention by the teacher. I was particularly encouraged to find that a colleague and pioneer in mental health consultation and its teaching, Beulah Parker, had recently written about the need for supervision to meet some of these problems (18).

THE MENTAL HEALTH CONSULTATION PROCESS

Learning mental health consultation may be difficult, especially for those mental health professionals already experienced in their generic practices.

Mental health consultation can be described as a process in which a consultant tries to help a consultee from another profession with a work problem.

The method involves a diagnostic appraisal of the conflicts which cause the work problem; dynamic understanding of the anxieties and of the form in which they are presented to the consultant; an assessment of the integrative capacities of the consultee; efforts to reduce the anxieties by the consultant's comments (which indicate his understanding); acceptance and personal experience with similar feelings; and conflicts engendered in the consultee by the behavior of his clients; and, finally, discussion of how similar problems

have been or may be handled by others so that the consultee is able to get some sense of how he might deal with the problem he presents.

The consultee often identifies with the consultant's attitudes toward the consultee's troubles and/or anxieties and sometimes with the methods by which the consultant deals with the consultee's anxieties. Thus, the consultant needs to have clearly in mind that his attitudes and behavior often provide a model for the consultee (5).

THE HANDICAP OF TRADITIONAL PRACTICE

The mental health professional—social worker, psychologist, or psychiatrist—who begins to learn consultation methods, must unlearn some of his traditional ways of working with people (18).

In this process the consultee is a collaborator, not a patient, client or counselee. His personal psychopathology is not the focus of discussion, which means that the mental health professional requires considerable reorientation. Since the process is an indirect one, it is also often a slow process. The results may not be evident for a long time and perhaps are recognized only in the reduced need for consultation. Thus, the satisfactions and rewards of individual psychotherapeutic efforts are often not present.

Even more than in individual work, when the process is effective the consultee may matter-of-factly accept the improvement in his work, sometimes not being aware of how he has been helped. When he is aware he may not acknowledge it to the consultant. Since the usual ways of gauging one's effectiveness and usefulness are missing, at critical moments it is often difficult for the consultant to refrain from

using the tried and true methods of individual psychotherapy. The result is usually an increase of problems in consultation.

My own experience has shown that those workers who have had training and practice in psychotherapeutic work with children and their parents learn consultation practice more readily. They have long ago learned to hear—in the complaints of the parent about the other parent or the child—disguised statements about the immediate patient. Therefore, in consultation they can hear in the consultee's statements about his concern with a client what he is saying about himself.

PROBLEMS IN INITIATING CONSULTATION

The contract in consultation which is to be an ongoing process may present problems because it may be honored in different ways. In all varieties of individual psychotherapy the understanding at the beginning of the work forms the framework for treatment. At least the person seeking help agrees to certain appointment times and fees and also commits himself to try to talk about his troubles.

In consultation where there is no crisis the initial agreement may be ignored; the time, place and conditions of consultation may seem never to have been talked about. The consultant is then faced with redefining the conditions of consultation by his own attitudes and behavior with the consultee. His efforts to help the consultee with the obstacles to his keeping the contract may be a necessary demonstration of the consultation process and vital to the development of the consultation relationship. The consultant may find himself initially giving lectures to staff, doing much direct service, etc., as part of developing the relationship.

In one instance, a principal asked the consultant to do a different kind of task each time; i.e., interview a child or a parent, visit a classroom, make a referral, give a speech to the PTA, etc., until he finally became convinced that the consultant really was concerned with understanding and helping the administrator and was not another *prima donna* from the superintendent's office concerned only with his special little project and his own professionally narcissistic satisfactions.

NORMAL ANXIETY IN CONSULTATION

Each mental health profession has its traditional roles and attitudes for reducing the practitioner's anxieties in dealing with the patient. The role of the person asking for help is also fairly clearly delineated. Thus, the self-expectations and expectations of the other person are quite clear. In consultation, however, there is no traditional role, and no clear expectation of consultee and consultant.

In fact, in any consultation session one may be faced with unpredictable crises and demands for their solution; unsolvable problems may be presented in which the etiological factors are unknowable for the time being, and understanding of the consultee's troubles and their meaning at that moment may be impossible to achieve.

As one colleague so clearly put it, anxiety is to be taken for granted as a part of the consultant's expected experience in most consultation sessions (15).

The fact that opportunities to understand and to become familiar with a particular consultee's methods of handling problems requires a fairly long experience together may burden the consultant with a great deal of uncertainty and anxiety for a long period of time. On the other hand, when one learns to accept the un-

certainty as part of the process, the attendant anxiety is reduced.

In its place comes a feeling of anticipation and pleasure in the creative application of one's knowledge, perception, and intuition. It does make consultation stimulating and may evoke from the consultant and consultee creative solutions to problems and constant growth in self-understanding and understanding of the consultative process.

THE INTRODUCTORY PHASE OF CONSULTATION

The honeymoon is an aspect of the get-acquainted period of most relationships and is a recognized and reckoned-with part of psychotherapeutic work. Most therapists look at this period as an interval between the patient's effort to establish a good impression on first meeting a new person, until the resistances and the characteristic modes of dealing with meaningful people in their lives assert themselves.

In the consultation process the honeymoon period is especially trying and deceptive because often overtly everything is going well, and covertly the consultee is complaining to superiors and colleagues that consultation is a waste of time and a humbug. Often the more anxious and insecure the consultee, the greater the discrepancy between the overt and covert communications.

Thus, the trainee consultant may be completely surprised and devastated when he hears the complaints. He also finds it difficult, then, to deal with the consultee about the complaints in such a way as to clarify and strengthen the consultation relationship. At such a point it is usually not easy to assess anew the past work in consultation, to understand where and why one has missed cues, and what one has not understood of the consultee's problems.

Furthermore, sometimes effective consultation may evoke anxiety and complaining which reflects the particular reality situation about which neither the consultant nor anyone else can effect change. Only continued consultation might reduce the consultee's turmoil. As in the matter of the problems around the contract, the consultant's efforts to explore the dissatisfactions, his ability to be nondefensive, to admit mistakes, his honest and earnest desire to be of help may solidify the consultation relationship as a result of such "honeymoon" problems; this might otherwise take many, many more months of consultation to achieve.

While the foregoing comments apply to ongoing or continuous consultation in general—as contrasted with crisis consultation—they have a particular bearing on mental health consultation with agency administrators. In my experience this is the most difficult and trying aspect of consultation to learn and, therefore, to teach.

CONSULTATION WITH ADMINISTRATORS

The administrator's position makes him especially sensitive and vulnerable to a threat concerning his handling problems concerned with authority, with status, and with possible failure in dealing with any difficulties concerning client or staff. As a result, many administrators feel they must never appear to be in need of help and must never acknowledge to superiors that they may need some aid in solving some problems. Often they also feel that they must not admit to any mental health professional that he might have knowledge or techniques which might be of use to the administrator in dealing with some problems.

One consultant found that while a school administrator made relevant refer-

als and seemed to appreciate help in understanding and working with parents, she also felt any regular meetings would be an acknowledgment that she was not a self-sufficient and completely competent administrator. It was only when this administrator's help was enlisted as a collaborator (in preventive mental health evaluations of children and in helping her teachers to be more effective in understanding, evaluating and using educative methods to help some of these very young, potentially disturbed children) that she could accept regular work with the consultant and eventually discuss a few of her problems as an administrator.

One of the most difficult problems in consultation, especially with school administrators—although this is true also of some other agency heads—stems from the combination of realistic pressures which keep them constantly busy and unavailable and their relative autonomy in the school. This makes it possible for a few administrators to shift their responsibilities to subordinates; thus they provide little actual leadership in the school and yet they prevent the subordinates from operating effectively with other administrative personnel by fragmenting their authority.

In one instance the responsibilities were divided between vice principal and head counselor so that neither had complete authority to handle a disturbed child, and whenever they made any effort to get together to map out methods of working together, the administrator would redefine the responsibilities for each person and defeat every effort to solve any difficult problems. In the resulting chaos, the principal would severely criticize each subordinate for falling down on the job, take matters into his own hands and exclude the youngster from school.

In other instances, an administrator had seemed to promote jealousy among his very bright and competent subordinates and kept them divided so that they were unable to work together as a team to solve pressing agency problems. Apparent anxiety about his job made these divisive efforts necessary so that the administrator felt less threatened. He repeatedly stated that despite his best efforts he could not get his subordinates to work together in solving the agency's problems.

The pressures incumbent in the job make it possible for the anxious administrator to be always too busy to sit down with the consultant for very long. Clients, staff, visitors and various meetings come first. These pressures also permit ostensibly legitimate demands to be made in terms of urgent referrals, direct service, etc., and may make it impossible for the consultant and administrator to meet to discuss other problems.

One of the most frequent problems consultants encounter with some public agency administrators stems from their conviction that they must undertake every assignment given to them, carry out every suggestion made by superiors, and that they must never say "no" to any demands from the community. These administrators are literally overwhelmed and often frightened at the enormity of their job and the fact that they can see no relief in sight.

Another difficult problem for the student consultant is the administrator who responds to the consultant's attitude of expertness by handling all his problems over to him for solution. He often demands constant reassurance from the consultant as well. Such administrators, and they are relatively few, react to the consultant's confidence and aura of competence and especially to his ready and help-

ful suggestions with regressive helplessness, as if they could not possibly exist unless the consultant remained constantly at their side to advise and help them.

Another very difficult aspect of learning consultation with administrators comes from the fact that sometimes one's most effective consultative work is most threatening to them. This is especially so in the kind of continuous consultation I teach, where the administrator is present at consultation with his subordinates (5). He can thus sanction any action that comes from consultation but, most important, as he is exposed to the consultation process, he can slowly learn by identification with the consultant how he may help his own subordinates more effectively with their problems.

If the consultant is not clearly aware of the administrator's anxieties and competitive feelings with the consultant he may attend only to the worker's problems and through his accurate and precise understanding of the subordinate's problems, help him with such apparent ease that the administrator may feel impotent and worthless because he had failed to help his worker. Thus the consultative relationship may be jeopardized. It is therefore necessary (although difficult) for the mental health consultant to learn to think on many levels at once, not only about the dynamics of the individual in front of him, but also about the dynamics of the entire agency and its varied personnel. This is no small task.

We have delineated at length some of the difficulties in mental health consultation with administrators so that consultants may become aware of how long it may take to overcome some of these obstacles, and also to suggest to consultants that in each situation one needs to give oneself suffi-

cient time to get to know the people involved; then one can begin to understand the particular anxieties and conflicts manifested in each of these difficult situations.

From such an assessment one can plan how and where the consultant's behavior, attitudes and help to specific persons in the agency hierarchy might begin to reduce some of the tensions and then to shift the forces a little bit in the direction of more integrative functioning of the administrative staff.

Since the consultant's purpose is to help the administrator to do his own job more effectively, the consultant must learn not to respond to helplessness by taking over administrative functions or decisions, since these are not his job. Nor should he participate in intra-agency strife by siding with either the divisive administrator or his impotent-feeling subordinates. Here the consultant begins to learn that divisiveness on the part of the administrator signals his need for help and support in certain areas of his professional work.

CONSULTATION VERSUS DIRECT SERVICE

I should also mention that in trying to help mental health consultants learn consultation I have become aware of the struggle each consultant has about whether consultation is as effective a way of helping agency as direct service. Of course, one of the vital factors is that the satisfactions inherent in doing direct service are not often forthcoming in consultation for a long time. Direct service, where the consultant does for the consultee what he needs to learn to do for himself, is also usually more promptly relieving and satisfying to the consultee. Thus, learning consultation may require, in addition to the vicissitudes of mastering a new skill, a delay both in

personal gratification from the work and in satisfying the demands of the agency.

THE LEVELS OF COMMUNICATION IN REQUESTS FOR HELP

The previously mentioned *need* to be attuned to many levels of communication is difficult to learn and to use effectively. Thus, each request for help may carry both a plea for aid and a warning that to act on the request is tantamount to saying to the administrator that he is not adequate. When, for example, a principal asks the consultant to go to work with a teacher about a problem child, unless the worker understands this request as a possible question about whose job it really is to help the teacher, the action of the consultant may disrupt the consultation relationship.

The consultant tries to make clear to the administrator by his attitudes that his job as an expert is to help the administrator with the mental health aspects of his job. In recent years difficult mental health problems are more often being presented to agency workers and thus to administrators. The need for help from mental health experts is correspondingly greater.

Requests for help or understanding of troubles from administrators are sometimes very indirect and vague. These requests need to be understood and handled by the consultant as an opportunity for some mutual appraisal of the request with the administrator. It is usually most helpful to react to an indirect request as an appeal for help to a subordinate about his problems with a client. Such requests are therefore usually better not responded to as a direct appeal for help by the administrator for his own problems.

Despite the many difficulties in learning to consult with administrators, I've come

to feel that the time thus invested is far more productive in helping staff and clients than any other kind of mental health service.

SOME PROBLEMS OF THE TEACHER

Anticipation of some of the most frequent anxieties and frustrations, hopefully, may reduce the feeling of failure of the trainee. Consultation vignettes presented to illustrate the common problems seem to be quite effective. Students have told of how they have recalled such vignettes at times of extreme frustration and have been able to view the situation a bit more objectively.

Process recordings of consultation sessions are important and valuable for the delineation of dynamics of consultation. Such recording makes possible a level of understanding the subtleties of the consultation interaction that is not possible when the trainee relies on his memory.

Supervisory meetings held with a skilled supervisor at least once a week are most helpful and probably essential to learning consultation.

I have found it most difficult at times to help some trainees not to use confrontation techniques when these skilled and previously effective mental health professionals find themselves hamstrung by consultees who avoid them, forget the meetings, or complain to colleagues about the failure of the consultant to be very helpful. On rare occasions it has been necessary for the trainee to use his "therapeutic skills" on the consultee so that he may experience first-hand the reaction of the consultee who feels he is being treated as a patient. Usually some role-playing by the supervisor, when he understands the meaning of the consultee's behavior in a partic-

ular instance, permits the trainee to observe how the consultee might react to various approaches.

The student consultant's failure to engage the administrator consultee in meaningful consultative work, because of the time it often takes to bring about engagement, may leave the student feeling most inept and futile. Such experiences may make the trainee certain that this process is an inefficient or an ineffectual one. I have found that it is easier to help the trainee persist in his efforts if there are several trainees, at the same point in their training, who can share their mutual frustrations and recognize that this is a phase in the consultation process.

The rewards in teaching consultation come when the trainee has been able to work through the many difficulties and can finally see the results of his efforts in the more effective work of the administrator with his staff, and of the staff with their clients.

I have come to feel that the trainee has mastered consultation practice when he begins to find fun and anticipatory excitement in consultation meetings; and when he follows his intuitive leads to realize the creative possibilities in mental health consultation.

SUMMARY

Mental health consultation, as differentiated from consultation to agencies of an educative or technical advisory nature, was first described by Coleman in 1947. Since then, many others, particularly Caplan, have enunciated the principles and practice of this process. It is an indirect method of focusing on the work problems of an agency worker to help him with the internalized conflicts which produce the problem.

In recent years both formal and informal teaching of this method has occurred. Mental health professionals need to unlearn some of their generic methods to learn this indirect method, in which their satisfactions are usually delayed. The initial contract is often ignored, introductory phases are often replete with disappointments as consultees complain they are not helped. Consultant-anxiety is an expected part of the process because of the many and varied implicit and explicit demands of the consultee. Administrators may be particularly difficult to engage in consultation because they may see it as a threat to their façade of adequacy. Problems of teaching center around helping the trainee to live through the inevitable frustrations as he learns a new technique.

The teaching and learning of mental health consultation is rapidly becoming one of the most vital areas in community and preventive psychiatry.

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Influence of previous help-seeking experiences on applications for psychotherapy

Previous reports (1,2) on the refinements of concepts and techniques which developed from the precipitating stress project have concentrated exclusively on one aspect of the data and on a single therapeutic goal.

That is, they have focused on the precipitating stress, on what brought the patient to the point of asking for help, and on understanding and working through this stress as the primary function of one kind of brief psychotherapy.

This paper will treat another aspect of this kind of treatment, one which has hitherto received only passing mention. It concerns the kinds of expectations that patients bring with them to the helping agency, and of the influence of these expectations on what transpires there.

In the most general terms, a person approaches each new moment in life as a product of his total personal history. He meets new situations as if they were like those he has previously experienced, and, hopefully, he works to discern the similarities and differences between the new and

the old and to react and adapt accordingly and appropriately. In those situations

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which are particularly important, highly emotionally charged, or which recapitulate many elements of the past, it is possible to observe, with special clarity, the characteristic approaches of a given individual to life circumstances. The application for help is one such situation.

Those patients who have had no previous experience with an officially designated help-giving agent will draw upon their informal recollections of parents, friends, bartenders, spouses, lovers, or casually corralled listeners. For others, the reactions of teachers, ministers, family doctors, attorneys, parole officers, etc., constitute a more formalized impression of the consequences of seeking help. Finally, there are those who have had anything from a casual brush to an extended personal psychoanalysis with our colleagues in the helping professions.

Thus, the background for forming expectations varies, but the expectations also vary—somewhat independently at least—of the objective background. People seek help in periods of personal disruption, during which old conflicts are revived. As a part of the revival, regressive attitudes and expectations which constitute a response to stress, rather than more characteristic modes of behavior, may appear. One may see misguided and undifferentiated trustfulness, pervasive distrust, feelings of helplessness, feelings of omnipotence, wishes for total dependency, or complete avoidance of dependent implications—in short, the whole gamut of feelings, defenses, conflicts, attitudes and expectations.

The issues involved are the inevitable ones of transference and resistance, but here the focus is on some aspects which have particular relevance both for brief psychotherapy and for the initial phases of more extended psychotherapeutic work.

Our attention was specifically drawn to a therapeutic focus on expectations by a number of patients in the study sample; for these patients a crisis regarding their experiences with other persons or agencies was the precipitating stress for the application studied. For other patients, these experiences and the expectations they promoted were a backdrop for a different presenting concern. In every instance, however, we concluded that our understanding of the patient and his problems was enhanced by an explicit awareness of his thoughts, feelings, and fantasies about asking for help and about what would happen when he did so.

Some individual cases will illustrate certain points we have delineated in our work. A persistently difficult kind of problem is the "hard-core" case, the individual or family known to many workers in many agencies, the multiproblem, multiagency client. Pressures of staffing and time frequently mean that communication among the agencies is minimal or absent, and referrals from one to the other for various aspects of the difficulties are haphazard or a product of desperation.

There may be disagreement and rivalry among the agencies themselves as to where the client most appropriately should be treated. It is not surprising in such circumstances that the client's problems proliferate. Even when it is possible to be most painstaking and thorough in the evaluation and planning, however, some of these cases are bafflingly intractable.

The following case exemplifies aspects of the client's and agencies' roles in such difficulties.

The patient, a 38-year-old Negro male, had had a number of hospitalizations for mental illness and was a diabetic as well. He had applied for help at another

clinic in the city, and they planned to see him for treatment. To complete their evaluation and stabilize his physical state, they asked that he be seen in the University Medical Clinic. The patient came to the Neuropsychiatric Institute instead, with the rationalization that he wanted a clinic where all his needs could be taken care of under one roof. What he seemed to mean was that he wanted someone who would see his helplessness and desperation and immediately inaugurate a complete treatment program for him.

His rejecting one clinic for another was partly a way of showing his resentment toward the first clinic for what he felt was the "run-around" they gave him, but it was also a way of escaping the frightening results of his own anger. He seemed to hope that he would get the amount of attention that he wanted—and get it immediately—in which case his anger would disappear. However, he entered new situations with the suspicion that his needs would not be met, proceeded to ask for more than could be given, and then left in muffled anger when his hostile suspicions were confirmed. One basis for his suspiciousness was his excessive demands for dependency and their consequent rejection. After some exploration of these expectations, the patient returned to the first clinic. In view of the hostility he still felt toward that clinic and the history and pervasiveness of his severe psychopathology, it is doubtful how long he was able to remain in that setting and out of a hospital.

One complication of this kind of case is that the patient comes in making a specific request—in this instance, "I need insulin for my diabetes." The worker's response often is a formalistic one to the content only; that is, "We don't have that kind of medicine at this clinic," rather than to the dynamics of the request.

In another kind of multiagency situation, the *patient* may be comparatively

comfortable with the help he is receiving (or with not desiring help) but a close relative is dissatisfied with the way things are visor, or in relation to the inexorable laws going, makes specific demands of an agency, and feels frustrated and angry when these demands are not met. Frequently, this anger seems to be a displacement from the offending, sick patient onto the agency.

In one instance, a mother became discouraged regarding what she felt was her son's lack of progress from a dependent illness. She decided that the difficulty lay in the agency's failure to prepare the patient to hold a job. There was a large element of denial of the extent and seriousness of his problem in her attitude of "He really would be all right if only he had a job."

In both the above kinds of cases, a response—whether it be yielding or unyielding—only to the content of the demand is inappropriate. Certain patients and their families phrase requests or present problems in a manner which practically insures their not being fulfilled. In the case of the diabetic man, this behavior was part of a characterological pattern which functioned, by provoking rejection, continually to prove to him his own unworthiness.

With the mother in the second case, anger at the son, which she was too guilty to express, could be directed toward the agency. In other cases, the form of the request may reflect distorted expectations about how one is supposed to behave in order to obtain help, confusion about the nature and extent of the difficulty, or, even more simply, an inappropriate response to a new experience.

As to the role of the helper in these situations, variables sometimes enter which are almost totally unrelated to the patient and his problems. The patient may, in consequence, become a shuttlecock in the

jurisdictional battle between a public and a private agency, in communication difficulties between a worker and his superior of the city, the county, or the state.

While the helper must, of course, operate within the framework of the helping agency, with whatever restrictive and/or facilitative factors this may introduce, movement within the framework is partially dependent upon a thorough and objective understanding of the problem at hand. Exploring with the patient the meaning of his request in terms of his difficulties and in relation to the realities of the agency's resources can be a meaningful brief therapy goal and, in some instances, serve to short-circuit interagency migration.

A second way in which an earlier help-seeking experience can significantly influence a new application occurs when the first helper, usually unwittingly, acts in such a way as to evoke an important internal conflict in the patient. It is of passing interest that in the precipitating stress study cases this evocation occurred in relation to the second category of helpers—school counselors, ministers, family physicians, etc., and in connection with a relationship of short duration. An intervention by the helper aroused a conflict in the patient which then revolved around the helping person, and the patient felt so threatened in dealing with this person that continuation of the relationship was not possible.

These actions are different in kind from another situation—to be illustrated later—which leads to a patient's feeling rejected by the helper. In the instances in question, the helper becomes the focus of a formerly extramural conflict. The issue of the appropriateness of the intervention appears irrelevant; what is important is the interaction between the intervention and the patient's conflicts.

For example, in one case a school counselor, concerned about a progressive emotional upset in a student and hoping to promote further help in an acceptable manner, suggested a checkup at the Medical Center, to rule out glandular involvement. The patient was aware that his problems were emotional, and his upset centered around suspicious feelings that others knew things he did not. With this action, he began to suspect that the counselor knew more about his emotional problems than he had let on, and the aura of secrecy served to upset him further.

In a third group are those patients who leave one therapist to apply for help from a new source. In some instances, this behavior is an acting out of a conflict belonging in the interaction with the previous therapist. These dilemmas usually arise in fairly long-standing relationships where the dependent attachment is strong and some situation intervenes which leads the patient to feel that his dependency is about to be threatened. The impulsive reaction of the patient is to flee before being rejected.

Frequently these patients apply to the new setting under the plausible guises of a job opportunity requiring a change of residence, a financial reverse making private care unfeasible, or even therapeutic progress that enables a move to a new community. While such factors may indeed be relevant, the therapist who is curious about the timing of such decisions is apt to learn that much more is involved.

One patient, for an extended period, had been in both individual and group therapy in another city. He came to the West Coast at a time when he was being dropped from individual therapy, but it was his group therapist, the clinic director, whom he held responsible for the change. The individual therapist was perceived as indulgent and supportive, while the clinic director seemed

to have sterner standards of performance, to which the patient had not measured up. He had interpreted the patient's behavior in the group as manipulative and had indicated, according to the patient, that interruption of individual treatment would be desirable, and he was dropped.

Thus, the patient was left only with the group, conducted by the person whom he felt angry toward and feared, a father figure whose demands could not be satisfied. It was at this time that the patient fled to a new city. He said, "I tried to understand [when interrupting individual treatment was suggested] that I wasn't hopeless, but that was the way I felt, that I really was a hopeless case and nobody could do anything for me."

A fourth and final kind of situation occurs when a helper can no longer continue in this role, either because he is not the appropriate person to deal with crucial aspects of the patient's problems or because discontinuation is forced by a factor like illness, agency policy, transfer from a service, etc. In many such cases, circumstances prohibit the working through of the patient's feelings about this compulsory termination, so that many of his reactions are transferred onto the new helper.

To deal therapeutically with such reactions requires an insistent focus—over considerable resistance—on the patient's feelings. There is an overlap in discussing patients of this kind with those previously mentioned who have made insatiable or unrealistic demands, have had old conflicts evoked by previous helpers, and have felt abandoned and rejected. As is true in all these cases, the expectations about treatment and their effect on the treatment process cut across various kinds of psychopathology and core conflicts.

One patient who applied in great distress had seen her general physician about her emotional difficulties over an

extended period. He perceived his role as that of facilitating a psychiatric referral, while she regarded it as averting one. Additionally, the relationship with him had dependent and sexual implications, in terms of the patient's yearnings, which were frustrating to the patient, anxiety-provoking to the physician, and disruptive of communication between them.

The physician finally set limits which the patient interpreted as rejection, and the psychiatric referral ensued. All of the attitudes, demands, anger, and guilt which had complicated the relationship with the physician were a part of the new application, but with persistence by the therapist and the license of partial removal from the source, the patient was finally able to explore some of these feelings.

These case examples have touched upon only a few of the many factors inherent in patients' expectations which have an important bearing on the therapeutic process. The whole issue of discrepancies between therapists' and patients' goals, for example, has not been discussed. Both may seemingly be unaware of the existence or extent of such discrepancies, but as noted in our previous reports, the interaction proceeds as if there were agreement about both expectations and goals. The case illustrations presented, however, carry some potential implications for practice.

In some instances, a favorable previous experience will maximize motivation and favorable prognosis for a patient. This paper has outlined some ways of dealing explicitly with the topic of expectations in the hope of facilitating such favorable experiences. The emphasis has been on focusing on and understanding as fully as possible the relevant expectations, with the assumption that such understanding promotes new learning and more effective management.

One inference that can be drawn from a study of these cases is that, as is true in other aspects of practice, clinicians need to become as alert to an automatic falling back on "agency policies" or "standard procedures" as they are to significant departures from such procedures.

For example, when a new applicant discloses that he is still in treatment with another therapist, how often is this information dealt with by saying, in effect, "Go back and settle this with Dr. So-and-So and then come to reapply if you both agree." This may be the very action which the patient is totally unable to carry through, and in this sense the "reason" for the new application. While responsibilities to other practitioners must be recognized, such responsibilities may often be most constructively implemented by an exploration with the patient of the circumstances and meaning of his behavior.

This conclusion touches on another point which is implicit in several of the case examples. A new therapeutic atmosphere may enable certain patients to work through aspects of their feelings about treatment which cannot, because of their intensity and in the light of the patient's resources, be dealt with in the situation in which they arise. For this to occur, however, requires a therapeutic sensitivity to the existence and cogency of such feelings and a neutral attitude toward the previous helper.

To convey either, "I know Mrs. X, or Y Agency, and they do excellent work," or "Yes, you were correct; we can help you so much better *here*" would, of course, completely destroy any opportunity to work

through feelings regarding the previous experience.

When these feelings are explored in the new setting, at least three general kinds of results can ensue:

1. The patient may decide to return to the previous helper, but with clarification about what had transpired between them and the implications for the helping process.

2. The patient may, out of the working through, achieve an adaptive balance that enables him to function without further help.

3. As a consequence of clarifying his feelings he may move on to more extended therapeutic goals in the new or even another, more appropriate, setting.

Like other therapeutic goals, these cannot be determined in advance, or unilaterally by either therapist or patient. What the therapist *can* provide is a framework of interest in the kinds of expectations that the patient brings with him about the helping process.

Regardless of the outcome, the exploration of feelings about these expectations will, in each instance, have served a goal-limited therapeutic purpose with implications for the patient's continued functioning and future expectations.

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The child psychiatrist in a state industrial school

INTRODUCTION

Even the child psychiatrist with previous experience in treating delinquent children in a psychiatric setting will find a largely strange and new world if he accepts a staff position in a state training school for delinquent children. He will face a host of philosophical, political, social and moral questions from which he had been happily shielded.

I shall describe one industrial school setting to demonstrate the value some of the experiences in a state school might have for child psychiatrists at some time in their training or early in their professional careers. Such experiences should leave lasting traces in the child psychiatrist's view of his role in society, even if he returns to a psychiatric setting. I shall also attempt a formulation of the unique contributions a child psychiatrist can make to

a state industrial school. The observations made here are based on my experiences as a group therapist and staff consultant at the Kansas Boys Industrial School (KBIS) in Topeka, where a psychiatrist has been on the staff intermittently for the past 12 years, and where a psychiatrist, with two additional years of training at KBIS, has been the clinical director for the past four years.

DESCRIPTION OF THE KBIS

The child population in KBIS is typical for similar institutions where there is no youth authority or other screening agency. Any juvenile court in Kansas can commit any boy under 16 found to be "miscreant" or "delinquent" to KBIS. The population

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of 175 to 200 boys ranges in psychopathology from mental deficiency through character disorders and episodic dyscontrol to the most severe emotional disturbances with more or less complete reality severance, hallucinations and other symptoms of disintegration. The actions which bring the boys to the school range from truancy and petty stealing to armed robbery and murder.

The first task after admission of a boy is to establish quickly what may have caused his difficulties and what his needs are. An initial psychiatric work-up with social history, psychiatric interviews, psychological tests, physical and neurological examinations, observation in the cottage, in the academic school, in the vocational school and in the recreational program is necessary to answer some of these questions.

After this study a treatment program is planned for each boy in a conference in the cottage, and the clinical director acts as consultant in this conference. Then the cottage co-ordinator¹ is in full charge of the program and continually implements and modifies it to make maximum use of the time available for treating each boy.² The clinical director is informed about the progress of each boy and is available for consultation when needed.

A newly admitted boy is met at once with the expectation that he will carry as much of a share of responsibility for his rehabilitation as the initial psychiatric work-up and further interviews indicate he is able to carry. Constant encouragement

and support are given throughout his stay to make it possible for him to assume this share. To the delinquent boy who expects another "law enforcement type" of approach from the staff, the attitude is a shock and a surprise and, of course, he does not trust it and has to test it actively.

Rather than telling him he must behave before he can win a parole, the staff tells him his stay at KBIS is temporary, that they wish to help him understand and correct his friction with society, but that he must assume primary responsibility for asking for and using this help. All the friction he creates, or the squabbles he gets into, are continually reflected back to him as evidence that he does not yet know how to get along with people, even when they obviously are friendly and on his side.

The treatment program aims at helping the individual boy to overcome some of the handicaps or pressures which presumably are causing his difficulties with society. This help may concentrate on alleviating or eliminating family, school or other environmental pressures on the boy, by doing social work with the parents or with community officials, or by arranging for a boy to live with a relative in another town. If a boy's frustration is caused by his having dropped out of school and he has no skills which can get him employment, the vocational program can offer him basic training and help him find employment or an apprenticeship in a trade when he leaves the school.

When the difficulties are due to more subtle reasons, a thorough psychiatric understanding is an absolute requirement before suitable treatment can be planned. Some boys coming to KBIS have never learned how to relate themselves to adults and may have been unable to get along with employers and other adults who have

¹ For a description of the function of the cottage co-ordinator see: Craig, L. P., "Reaching Delinquents Through Cottage Committees," *Children*, 6(1959), 129-34.

² The average stay has had to be reduced to 12 to 15 months in order to avoid severe overcrowding of the cottages.

tried to approach them. These boys need help and support in developing a relationship with the adult staff member (the cottage co-ordinator, a child care worker, a teacher, etc.) toward whom they tend to gravitate.

If the difficulty stems from lack of an adequate male identification figure, the boy may, for example, be placed with a certain vocational teacher who, through the vocational activity, can make contact with him and provide a suitable model for identification. Or the boy may be placed in group therapy, where he sees other boys identifying themselves with the therapist, and he gets the courage and tools to do likewise. In still other cases, the inroad to the boy may be made through the chaplain or priest ministering to his religious needs, or through the school coach.

Many boys are emotionally immature, incapable of impulse delay, or of tolerating anxiety. Here a program of "ego building" may be indicated. This provides means of strengthening a boy's defenses against inner impulses by, for example, continuously and promptly showing him that much of the pain he experiences is caused, not by others, but by his own rampant impulses. "Ego building" involves finding things which the boy can do well or better than most. This gives him a greater feeling of self-worth and the confidence that taking responsibility and accepting his approaching adulthood is something to look forward to and enjoy, rather than something to shun or fear. When he takes up the fight against his impulses, the staff offers him support and plans his limits.

Those boys who primarily need psychiatric treatment or special remedial rehabilitation are transferred to state hospitals or to institutions for the retarded. Channels

for the transfer of these boys have been set up, but the waiting time is sometimes very long. In Kansas, special legislation allows any child to be freely transferred from one state institution to another. For example, boys can be transferred from other state facilities to the industrial school without going through a juvenile court, while a severely disturbed child can be transferred promptly to a state hospital without losing the protection and jurisdiction of the court. (The boy's relatives, for example, cannot interfere with or prevent hospital treatment.)

Ataractic drugs are used temporarily with some boys in KBIS. The many advances in this field are continually studied and applied within the limitations of the institution.

TREATMENT PHILOSOPHY AND RESULTS

Even if they should want to do so, the handful of clinically trained staff members at the KBIS could not offer conventional psychiatric treatment, even group therapy, to more than a relatively small number of boys. The clinical staff is convinced, however, that the KBIS should not be a psychiatric treatment center.

The staff feels responsible for the maximum rehabilitation of *all* the boys admitted to the school. They have also decided against waiting for more professional staff, a delay which, in many other centers, has resulted in a total collapse of a treatment program already started.

To make maximum use of their skills, professional staff members have been decentralized to the cottages where each is now directly in charge of the treatment program as well as the inservice training in his cottage. This arrangement has all but eliminated time for individual therapy,

and although the professional staff members continue to do group therapy with boys in cottages other than their own, this can be done only on a limited basis.

All professional people thus put in charge of a cottage as "cottage co-ordinators" are now responsible for the implementation of the treatment program of each individual boy in their respective cottages. They continue to offer examination services within their own professional disciplines; for example, psychological testing on a school-wide basis. This arrangement is based on a rethinking of the entire concept of "treatment," and on a redefinition and streamlining of the purpose and goals of treatment. Although moving away from traditional child psychiatric treatment, child psychiatric principles and experience have provided the guideposts in setting up the new program.

Psychiatric experience in delineating and defining the functions of a children's clinic or a residential treatment center prompted a re-examination of the role of KBIS in relation to the need it had been set up to serve. It was then realized that the state of Kansas had not set up nor staffed the industrial school as a psychiatric treatment center.

Furthermore, experiences with conventional types of psychiatric treatment within the school had made it clear that conventional psychiatric treatment did not meet the needs of the great majority of the boys in KBIS and thus would not deal effectively with the statewide problem of juvenile delinquency. It would, therefore, be difficult, on professional grounds, to justify a request for the much larger appropriations which conversion to a psychiatric program would require.

Boys usually have been sent to the industrial school because they caused difficulties in their community or because they

repeatedly harmed or maligned individuals. All the community expects is that the boys will be changed to the point where they no longer will cause trouble.

Drawing freely on child psychiatric knowledge and experience, it has proved possible in KBIS to set up an effective treatment program which has rigidly defined, rather narrow and limited goals, but which provides the community and the boys with essential help. The goal is strictly to get the boys to the point where they will no longer cause difficulty for themselves with society.

The school gives this one specific kind of help, expecting other community institutions, as well as the boys, to arrange for other necessary help. The KBIS through its psychiatric study and work with the boys, of course, has a first-hand opportunity to define their needs for other kinds of help, and concerted efforts are made to assist both the boys and their communities to recognize the boys' additional needs at the time of discharge from the school.

Some boys, having given up their acting-out defenses by the time they are paroled or discharged, have become deeply neurotic, troubled, anxious, or even depressed. Psychiatric outpatient facilities are now available for these types of difficulties in a number of Kansas communities. Whether or not the facilities actually are used is up to the boy and those assisting him in the local community.

An important strategic value of this way of thinking about rehabilitation is that many children who get into trouble have intense, unresolved dependency needs of an infantile, clinging type. Offering boys psychotherapy for a long time in the institution, without their making any sacrifices or efforts for it, in our experience, far too often leads to the development of intense passive dependency on the institution.

Such a dependency could be prevented or counteracted more actively in a well-staffed institution, but even there the question would have to be raised as to whether it is justifiable to assume that much responsibility for a boy's life.

This is particularly important in a state industrial school, as many of the boys come there from deprived backgrounds where they never had had regular meals, adequate housing, clothing, care, or recreational activities. Leaving the school to go back to a deprived life, therefore, is difficult for these boys, and possible only if they are strongly supported in doing so by the staff.

In the usual residential treatment center, the treatment goal is determined by the child's potentials and by how these can be used to insure maximum growth in the child. In KBIS, the staff helps the children concentrate on one aspect of their lives—their repeated or constant clashes with society. Resolving this problem cannot be accomplished unless the boys are helped, at least to some extent, to resume their psychological growth, to accomplish a greater degree of self-awareness, self-worth and self-confidence.

In the program described, it is not always possible to accomplish this, and the staff must expect a percentage of failures. The failures or near failures, about 30 per cent, are a constant reminder and challenge to the staff that the program still is not what it might be.

Most baffling and discouraging are the boys, comprising 5 to 10 per cent of all admissions, who are self-destructive in a major way, aggressive and aloof, who keep escaping from the open setting, and never even become physically available for rehabilitative work. These boys do not respond to any known treatment and much research must be done to understand what

lies behind the self-annihilative behavior of these particular children. Such research may well lead to an enrichment of our current understanding of aggression and the vicissitudes of aggressive drives.

Among the 70 per cent of the boys with whom the program is reasonably successful, many are able to resume growth to an amazing degree once their channels of communication and capacity for useful identification are restored. An increasing number of discharged boys now continue their academic education, which was practically unheard of before the present program was put into effect. The school now, for the first time, has sports teams which compete with teams out in the community. Several years in a row, the intermediate KBIS basketball team has won the championship in the local YMCA league. The boys proudly play hosts, with name cards pinned on their shirts, at the annual open house for the public.

While no claim is made that it is necessarily a more efficient or desirable program than many other possible ones, it does appear to reach a larger number of boys in a more meaningful manner. A longer observation period and a follow-up study, now in progress, will be required before it can be established whether the present program is doing as well as it seems.

RELEVANCE TO CHILD PSYCHIATRY

A child psychiatrist working or acquiring training experience in a setting like the KBIS gains a perspective of his psychiatric knowledge and of his profession in relation to society which cannot be easily obtained elsewhere. This experience helps the psychiatrist to become aware of the current need to reconsider the role of child psychiatry in society (due to the long waiting lists at clinics and the huge number of children in need of attention) and can have

an impact on how child psychiatrists will view the community aspects of clinical psychiatric settings.

The child psychiatric trainee in an industrial school will be able thoroughly to observe and to study the psychosocial changes and upheavals of adolescence. He will better understand the profound influences on adolescent development of cultural and socioeconomic factors, and will learn to value and use personality assets and strengths to a greater degree than in a psychiatric setting. He may even be induced afterwards to join the handful of colleagues who have established, developed and expanded badly needed residential treatment facilities for emotionally disturbed teen-agers.

Work with adolescents, even more than with younger children, requires self-knowledge, fortitude and maturity in all staff and, in particular, in the person or persons in charge. Disturbed adolescents have an uncanny ability to sense and exploit the weaknesses and unresolved conflicts of adults working with them, and they may react with violence or other outbursts when they manage to seduce the adult authority figure and, consequently, feel unprotected.

The raw, unbridled aggression in a number of children in an industrial school will give the child psychiatric trainee ample opportunity to work through his own remaining anxieties and uncertainties which will benefit him in later psychotherapeutic work.

The child psychiatrist will also come to see his usual diagnostic framework in a new perspective, not only because of the inherent diagnostic difficulties in adolescent patients (most of the children in industrial schools are teen-agers), but also because of the constant clashes between the legal definition of delinquency and the

child psychiatrist's own definition as to what is and what is not "acting-out" behavior. He soon will come to realize to what degree delinquency is a legal and a social problem, and that psychiatric knowledge represents only one of many avenues along which the delinquent child's difficulties will have to be viewed to reach an over-all understanding and intelligent approach to rehabilitation.

A low intelligence quotient and feelings of inferiority are not necessarily more important than such factors as lack of parental supervision, rejection by local high school teachers, the fact that the local teenage culture puts a premium on daring behavior rather than on compliance or scholastic achievement, laxity and inadequacy in law enforcement, with resultant easy access to hard liquor for even younger teenagers, lack of local employment possibilities, severe racial tensions, etc. Any "good" child psychiatric work-up should and does take all such factors into consideration, but they are rarely faced as strongly as they have to be in a state school for delinquents.

In this setting, the child psychiatrist must concern himself with all these aspects of community life. The more he finds out about them, the harder it is to decide whether the main etiologic factor is the demonstrable psychological stress in a boy or severe environmental pressures or deficiencies in the boy's home or community. Where the emphasis is placed makes a big difference in planning treatment or in the charting of a prognosis.

The demonstration of internal conflicts in a delinquent boy is not necessarily relevant to the immediate situation; the conflicts may not explain the delinquent activity or it may be only peripherally related to it. A 14-year-old boy, abandoned with four younger siblings by both parents in

his home in a big city's slum district without money to buy food, very likely will show internal conflicts. Yet, the fact that he stole and landed in an industrial school may have nothing to do with these conflicts and may merely reflect his struggle for survival.

Considering the background and environmental pressures of many of the boys, the child psychiatrist will be impressed that many of the boys are still as healthy as they are. Trained primarily to recognize psychological difficulties, he will also learn in this setting properly to value psychological assets, strength and resiliency, all of which represent growth potential and can provide leverage in "reaching" and rehabilitating a boy.

A boy may appear disorganized, negativistic or inaccessible when admitted, but his response to the program in the industrial school may still be faster and more positive than an inexperienced observer would expect if the boy, for example, has experienced just one positive relationship with some person older than himself—a brother, uncle, or teacher, even though the relationship was temporary or intermittent.

In planning the treatment program, the child psychiatrist in an industrial school must also rethink much of what he has learned in his training. Traditionally, he has learned to administer individual therapy, through drugs, counseling, psychotherapy, etc. His training may also have included group therapy and other modes of treatment. However, these modalities of treatment, particularly individual psychotherapy, may prove inadequate or even directly undesirable in a state industrial school.

To give an example: Intensive psychotherapy leads, in some boys, to major regressions which cannot be handled ade-

quately in cottages where four to five child care workers cover shifts around the clock for 30 to 40 boys. Further, some boys oppose therapy, even though they are excellent candidates for it, once they learn that it is likely to triple or quadruple their length of stay. Anger, suspicion, and guilt may result. Such negative attitudes to treatment can become major, time-consuming obstacles.

Group therapy in a setting like the KBIS similarly cannot aim at psychological rehabilitation or at lessening the psychopathology of individual group members, but it will serve its purpose if it helps group members become able to talk comfortably with the adult therapist and the other boys. This comfort invariably carries over into relationships outside the group.

Beyond the usual experience of the child psychiatrist is also the planned and full use of community facilities during a boy's stay at an industrial school and upon his discharge.³ Some boys may need the richer educational opportunities of a public high school in a nearby community while they still are at the industrial school.

Public and private facilities can offer casework services to parents living too far away from the institution to be able to come in for services there. The child psychiatrist must participate in community education in the state, particularly with the elected juvenile judges and law enforcement officials. Occasionally, particularly when a boy whose remaining psychopathology is subtle or hard to understand is going to be paroled, the child psychiatrist may be the person from the industrial

³ See Toussieng, Povl W., "The Role of the Psychiatric Consultant in a State Training School," *Federal Probation*, 25(1961), 39-43, for a discussion of the need for an industrial school accurately to reflect the society it serves.

school most suited to preside over a conference in the boy's home community with his parents, local school officials, law enforcement officers, parole officers, social workers, recreation directors, ministers, youth leaders, and judges.

CONTRIBUTION OF THE CHILD PSYCHIATRIST

The child psychiatrist is exceptionally suited to implement and sustain the program described. He follows a long tradition of working together with and co-ordinating other professions and vocations. In an industrial school, the child population is hypersensitive to errors in understanding or tensions in the staff, and rather subtle causes may set off massive self-destructive, sometimes even suicidal behavior.

Indirectly, support from the psychiatrist will enable other staff members to face and help share some of his responsibility and to realize the seriousness and importance of their professional roles within the total administrative structure of the school.

While professional staff members have been trained to make therapeutic use of themselves, other staff members—many of whom spend much time with the boys—will need training and continued support and supervision in order to accomplish this. All staff members must thoroughly understand and support the program, and must learn to be candid and scrupulously honest with the children. Staff must not merely be skilled in their individual vocation; they must also have a reasonable amount of personal integrity and not allow themselves to depend on the boys to satisfy their own emotional needs. Only then can they be the suitable and highly necessary identification figures and models so essential for many boys.

Once a boy has identified himself with a

given staff member, that staff member must be willing and able to help the boy realize that he now has acquired the ability to identify himself also with other adults outside the school. The identification figure serves as the boy's bridge back to the community, rather than as his only mainstay in life.

After all relevant findings are synthesized into an over-all formulation of a given psychological picture, the child psychiatrist can interpret to the nonprofessional staff exactly what the "disease" process is in a given boy, what healing is, how healing is proceeding, and exactly in what way given staff members can contribute or are contributing to the healing process. He explains to them the intrapersonal, intrafamily and wider interpersonal dynamics in operation.

Residential treatment of children in a clinical psychiatric setting has taught the child psychiatrist much about the need for communication and mutual respect between all the people working with a child. The psychiatrist teaches the therapeutic use of group living in the cottage, as well as of education, vocational and recreational activities. He helps other staff members recognize the pitfalls of becoming overly involved with a certain child, thus becoming, in the child's mind, a competitor with his own parents. The psychiatrist also helps other staff members to define clearly their special role.

While members of various professions do identical work—for example, in the work of cottage co-ordinator—they cannot function adequately if they lose their professional identity within their special field. Thus, the psychologist, the social worker, the chaplain, the teacher, continuously need assistance in redefining their professional roles and in understanding and appreciating the unique contribution only

they can make to the program. They must come to understand their therapeutic role and learn not to give in to the temptation to "therapeutize."

Industrial schools thus have much to gain and much to offer in a closer contact with child psychiatry. Low salary scales, as well as lack of appreciation of what a child psychiatrist can contribute, prevent many state industrial schools from recruiting child psychiatrists for their staff. A onetime obstacle—the punitive, retaliatory focus of some programs—is now practically eliminated in all state industrial schools which are not being used as tools for political patronage.

However, another obstacle, the insistence of some child psychiatrists that the indus-

trial school be converted into and staffed as a psychiatric treatment center has not yet been eliminated. Many child psychiatrists are, furthermore, loath to take on the enormous load of initiating a new program in an industrial school. Much education needs to be done both in our own ranks and among pertinent state authorities to bring about a closer collaboration between the two fields. This should be of great benefit to both.

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Psychiatric consultation with nurses on a leukemia service

Articles have appeared in the psychiatric journals asking psychiatrists to function in closer association with their medical colleagues.

The general hospitals now being built are including psychiatric units in their expansion program, and psychiatrists are invited to participate in the councils of hospital staffs. Psychiatric liaison services are being established as an adjunct to the medical and surgical activities of the general hospital.

Such liaison services function primarily as consultants to the physicians in cases of emotional decompensation associated with medical or surgical stress. There is another important role which might be considered. The work of Meyer *et al.* (4,5) indicated that the therapeutic milieu in

which the patient is treated—including his reactions to, and relationships with nurses and doctors—is of significance in the medical and surgical treatment of his disease.

The physician who had heretofore considered the healing process to take place within the patient himself (one-party system) has begun to recognize that therapy takes place as part of the total environment (transactional system of doctors, nurses and patients). It is almost naive to believe that getting well has to do only with the patient himself. As demonstrated by Caplan, the environment in which the patient lives while getting well is very important in the therapeutic process (1). Hospitals may sometimes be supportive and at other times actually detrimental to the patient's well-being.

With the assumption that a better understanding of oneself can improve the therapy of patients, we undertook a psychiatric consultation program with nurses on

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a leukemia service in order to assist them in understanding something of their relationship to patients, doctors, and to each other. It was our hypothesis that such a program could materially assist the nurses working in this very difficult environment by reducing their own anxieties, making comprehensible some of the irrational behavior and feelings expressed by patients and their families, and by affording the nurses alternative ways of coping with these problems.

METHOD

A group was established on a voluntary basis. It consisted of head nurses of the day and evening shifts and several of the floor nurses. There were two licensed vocational nurses included, and usually the medical-social worker and the ward physician attended. The meetings were held immediately after the report was given to the evening shift, and lasted from 60 to 75 minutes. Attendance was not made compulsory, but regularity in attendance was encouraged; occasionally this necessitated changes in days off.

There was some structuring of the meetings in that each week someone was asked to bring in a problem which she felt existed for her. She was encouraged to look at the information which she presented and offer some personal interpretation, with respect to herself or to the patient, or both. Then the discussion was open to everyone who chose to share her own experience with the patient. They were encouraged to voice criticisms, comments and corrections about each others' presentations. Initially, the nurses tended to defend one another's behavior rather than to examine it.

The consultant offered no value judgments about the methods used by the nurses to deal with their own feelings or

interpersonal conflict with the patients. Statements such as: "You should have" were studiously avoided, as they tended to increase the feelings of guilt in the nurses.

(It is to be noted that the attempts to offer help to someone with acute leukemia, when that help offered is of such limited value, had its own intrinsic guilt-producing effects.)

In the very early meetings, the nurses presented problems about patients who showed emotional upset on the wards, and they wanted specific information on what to do about this. While their demands for "how-to-do-it" information was not completely disregarded, the consultant directed the discussions toward "let's look at the problem and see how it happened."

Instead of offering to the nurses new modes of therapy, the consultant tried to help them develop within themselves an attitude of how to discern something about the etiology of the problem. As will be shown later, once they understood "how it happened," they could evolve a "what to do about it" on their own. A case in point will be presented.

V.S. was a 52-year-old woman who had been admitted to the leukemia service in July, 1961, with a diagnosis of aplastic anemia, which was thought to be the result of therapy with chloramphenicol. Initially, she had been a friendly, outgoing, co-operative individual, but with repeated episodes of an anemic crisis, her personality had changed.

She required two or three transfusions per week, each time in a crisis situation, and on several occasions appeared to be terminal. Her relatively long hospitalization of four months on this kind of service enabled her to experience the death of many other patients with whom she had become acquainted on the ward. This no doubt contributed to her emotional disturbance.

Gradually Mrs. S. became withdrawn, depressed and infantile. The nurses who sensed her deep feeling of depression were overwhelmed and responded to their own helplessness by infantilizing her. They bathed her, changed her linen when

she had "accidents in bed," spoon-fed her meals and ignored her deteriorating speech pattern, including her profanity and disorganized speech. Mrs. S. continued downhill until she eventually became psychotic with hallucinations, delusions, ideas of reference, loss of contact with reality, loosening of associations and inappropriate affect.

The patient was referred to me for evaluation and within a brief time had reconstituted (probably as part of a flight into health). The patient stated that it was easier for her to live with a dread of aplastic anemia than to think of the possibility of becoming psychotic.

Since the consultant had contact with the patient, he was able to see her relationship to the nurses, as well as the nurses' interaction with her. The following transaction phenomenon was elicited:

The nurses experienced the feeling of hopelessness and helplessness about the case, and this caused them gradually to withdraw from the patient. The patient became frightened by the nurses' withdrawal and regressed to a more dependent behavior. The dependent behavior encouraged the nurses to move in and help the patient, chiefly with her basic needs of feeding, dressing and personal hygiene.

At this point, the nurses lost their feelings of helplessness in relationship to the patient and were able to attend to her in a way which seemed meaningful. Now the patient could relate to the nurses, and she responded by becoming more regressed. This eventually produced a downhill psychotic state.

In summation, then, at a nonverbal level: Perhaps, in a completely unconscious way, a pact was established between the nurses and the patient to keep each others' anxieties at a minimal, by relating to one another in a "mother-child" fashion. This mitigated or denied a real threat which was constantly present for both; i.e., the aplastic anemia. The patient utilized a

denial defense, and this denial mechanism was reinforced by the nurses.

After our discussion of the case, the nurses stopped infantilizing the patient. She was encouraged to feed herself, bathe herself, take care of her own personal hygiene. She was begun on a program of occupational therapy and was encouraged to mingle with other patients. She was given a pass to go home and with the recovery of her medical disease, was eventually discharged.

The discussion with the nurses about the uses of infantilization of the patient (the traditional medical role) took a new twist when it became apparent that this mode was intensified by the nurses in order to reduce their own feelings of helplessness and anxiety.

RELATIONSHIP TO DYING PATIENTS

The question was raised about the possibility of alternative ways of relating to patients with serious diseases who have a poor prognosis. The purpose here was not to depreciate the methods which they had traditionally used, but to propose an additional mode of treatment which might complement what they had learned in nursing school.

One of the members of the group volunteered her feelings about getting too close to the dying patient. She admitted that she experienced fear and anxiety and also guilt that she had not done enough, or was not doing enough. This feeling of guilt always produced distance between the nurse and the patient. We explored the sources of this guilt feeling.

In a primitive way of thinking, patients with chronic diseases often believe that those people involved in treating their illness are in some way responsible for the causation of their illness. Strangely

enough, this belief is sometimes incorporated by the nurses, who almost feel responsible for the illness they are attempting to treat. It might be compared to "the feeling of identification with the aggressor" (3)—which in this case is the disease process—that causes the nurses to experience this guilt.

The revelation by this kind of insight, with a brief discussion about these mental mechanisms, reduced the intensity of the guilt and anxiety. A licensed vocational nurse said, with a note of amazement in her voice, "I guess since we don't cause the illness, we needn't feel guilty if we're unable to cure it."

Many discussions on the nurses' relationship to the dying patient were held. Each participant in the group was encouraged to express her views in terms of her relationship to a specific patient whom she nursed and who subsequently died. The reactions of the nurses varied considerably, but certain characteristic features emerged. The nurses all expressed their fear of discussing death with the patient, even when the patient himself raised the subject. Instead, they mollified their own intense anxiety feelings by refusing to discuss this subject.

They said that when it was evident that the patient was not going to survive, and despite the fact he was not in pain, they could not bring themselves to talk with him. They limited their visits to his room and avoided a relationship with the dying patient. While this was not true in every case, there was a significant amount of case material which substantiated this behavior. Paradoxically, pain was almost the welcome intruder, since the nurses could administer pain medication (usually shots) which produced a feeling of usefulness and afforded a subject for discussion between

the patient and the nurse. It also made for body contact, since the nurses would fluff the pillows, straighten the blanket and talk with the patient for a few minutes at this time, where previously they found it difficult to walk into the room.

The nurses were able to share their feelings of intense anxiety about death, and they expressed their methods of moving away from these patients. However, as their fears were expressed, the nurses seemed to be able to relate better to the patients. The dying patient could be viewed as someone with a very limited life span, but nevertheless very much alive.

Moving away from him increased a withdrawal feeling in the patient and intensified his anxiety about his own demise. He experienced abandonment. Not unlike the situation in a primitive society in which a person has had "the bone pointed at him"—see "Voodoo Death" (2)—our modern society also withdraws from the dying patient, who is sometimes very much alive up to his last breath.

As a result of the group discussions, the nurses were able to visit with the dying patients and talk with them about whatever subject the patients chose, including death. This was not accomplished easily, and not all at once, but slowly and with some difficulty.

RELATIONSHIP WITH FAMILIES

Some of the major difficulties encountered on such a service, from the point of view of the nurses, were the problems presented by the patient's family and relatives.

The families of patients (who ostensibly were present to aid and comfort the patient) would, at times, increase the general anxiety in the patient's room and on the nursing floor. They criticized, cajoled, chided and obstructed nursing

care in specific instances. While this was not true of every family, enough cases were presented to warrant discussion.

The nurses, who had had excellent rapport with the patient, would, at times, find themselves with suppressed hostilities, if not rage, with the patient's family. This antagonism would spill over in their relationship with the patient, and in a short while the nurses might find themselves staying away from the patient entirely in order to avoid the relative. This, in turn, would produce a feeling of guilt and self-recrimination in the nurses.

Understanding of the family of the patients who have leukemia and methods of coping with families in a crisis presented topics for discussion. Although this was related only indirectly to the patient, it affected the well-being of the patient, his family, and the nurse. It became evident early in our discussion that what the nurses found of greatest annoyance was a multitude of questions from the family about the medical and nursing care, with a covert suggestion that it might be inadequate. The answers given by the nurses only led to further questioning and, eventually, the nurses experienced a feeling of hopeless frustration with the family members.

One of the nurses said, "Sometimes the family member was outright critical of the doctors to the nurses, and critical of the nurses to the doctors, playing one against the other." To enumerate the various techniques which the families used to deal with their tragic feelings during this kind of crisis would require another paper.

Following our discussion, the nurses were better able to see the irrational behavior of the families as emotional defensive behavior. One nurse said, "Perhaps the best way to cope with this problem is to circumvent all the questions and deal chiefly with emotional feelings of the family." While

this technique requires additional skills of coping and some understanding on the part of the nurses about mental mechanisms, such knowledge could be communicated to the nurses relatively easily. Without attempting to be psychotherapists, the nurses were encouraged to deal with the feelings of the family, rather than with the intellectualizations brought to them in the form of questions. We would like to cite a case history to this point:

T.B. was a 16-year-old boy, who had Ewing sarcoma with widespread metastasis. He had received radiation and drugs elsewhere and was brought to this hospital in a last desperate attempt at treatment. His father, at this point, stayed with him constantly and was angry with the staff at the previous hospital. He was also overtly hostile to the nurses on our service and prevented them from bathing, feeding and giving medication to the boy. He questioned every procedure performed and the more explanations given him, the less satisfied he seemed to be. He restricted all visitors and, in his deep distress, almost prevented the nurses from entering the room.

Following our discussions, one of the nurses had an encounter with the boy's father. She wanted to go into the room and bathe the boy. His father blocked her from entering the room, questioning her various procedures, and the reasons for things being done at this particular time. The nurse looked at the father and said in a quiet way, "Mr. B., I know how you must feel. I had a child and, like your son, he fell ill and eventually died." The patient's father, at this point, burst into tears. He wept and the nurses comforted him. From there on he was a genuine asset to the nurses in helping them rather than obstructing them in the performance of their tasks.

The nurse had "tuned into" the man's anguish and loneliness. She had short-circuited the intellectual barriers which he had established by her simple yet direct empathic statement. She was able to establish a working relationship between herself and the father.

RELATIONSHIP TO PHYSICIANS

Another phase of the discussion led the nurses to express some of their feelings toward the physicians. Several of the nurses expressed anger toward the physicians for not having "a cure," and others expressed anger at the physicians for not letting the patient die. This was probably the most heated phase of the discussions, since the principal emotional defenses within the nurses were over-identification with the patients and projection of patient needs, wishes, fantasies, hostilities, depression, etc., onto the physician.

The nurses' feelings toward the physician were manifested by their relationship with the physician, the numbers of requests made by the nurses of the physician, the manner in which help was given to the physician, and, interestingly enough, the number of reports which the nurses made to their supervisors with respect to their conflicts with the physicians.

While the conflicting attitudes of the nurses toward the physician were not consistent, they were present in one form or another. Ambivalence toward the physician was noteworthy. The perception of the physician was one of the "omnipotent being" with "yet unused medicines with which to cure the patient," and on the other hand, as a "cruel experimentalist," using the patient as a guinea-pig.

After the nurses could make conscious their feelings and thoughts with regard to their relationships with the physicians, their own irrational and infantile needs could be mastered. There was a recognition that the physician uses whatever

tools he as a medical scientist may have, no more, no less. He was perceived in more realistic terms, which included, incidentally, his human weaknesses. He was shown to have fears of death, feelings of helplessness, and periods of doubts, without diminishing his status or his stature as a healer.

SUMMARY

The nurse on a leukemia service is faced with numerous problems which can be helped by psychiatric consultation. She can be helped to deal with patients who are dying. She can be helped in her dealings with the families of seriously ill patients, and she can be helped to understand her own relationship with the physician, with whom she must work. Over and above all this, she can be helped to understand how to master her own anxieties and therefore can help herself to deal more effectively with the nursing management of a catastrophic disease.

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Unique aspects of university health service psychiatry

In the past three decades, several thousand papers have been published anent the mental health of the American college student (1). Relatively few of these papers have been devoted to the perplexing dilemmas and conflicting responsibilities that are the lot of the college health service psychiatrist or counselor.

As will be illustrated in this paper, the psychiatrist who is also a campus functionary is in a position of far greater responsibility than his counterpart in private or mental hospital practice. The health service psychiatrist is called upon to meet the needs of his patients, but he must also consider the welfare of his employer, the uni-

versity, to say nothing of the local community.

He may have to spend an hour with a highly motivated, articulate student who voluntarily comes for help with a neurotic problem and in the next hour may find himself confronted with a bitterly reluctant freshman ordered by his dean to report to the psychiatrist. Constantly pressed for time, he must continuously make decisions as to which patients to terminate and which to see for a few more interviews. He strives to treat all communications from patients as privileged; yet at times he must convey to an anxious administrator precisely why he feels a student should not be expelled.

In the same hour he may have to explain to a skeptical academician that student A has a foreign language block and will need to have his language requirement waived, and write a pontifical letter to a

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local judge prophesying that student B will probably not be guilty of committing a certain nuisance again. All too frequently he must make decisions of vital importance in the lives of students—decisions that he knows are often based on no more than educated guesswork. Yet they must be made, either because there is no one else better-equipped to make them or, more likely, because no one else is willing to take the responsibility for doing so.

How does this differ from the private practice of psychiatry? In private practice one rarely makes decisions for a patient, most of whom come voluntarily. If a private patient asks his psychiatrist whether he should get a divorce, change curricula, or accept a certain type of job, he is quite properly told that these are decisions that only the patient can make, although the psychiatrist may help him to clarify his feelings on these issues. Not so at a health service where the student is often sent, primarily, because someone wants a decision made. I will use a seemingly trivial example, but it must be borne in mind that there was nothing trivial about the episode for the student.

Preceded by a phone call from her academic counselor, a coed came to the Mental Hygiene Clinic during the fall registration period. She had enrolled as a freshman the year before, had done failing work, and suddenly departed before the end of the semester. The counselor wanted to know if she should be permitted to re-enroll in view of her previous academic failure and her abrupt departure from the campus.

The interview that followed brought out that the young woman had been a better than average high school student and had come to the University of Michigan because her boy friend was already enrolled there. There were several quarrels and the boy friend often tormented her by dating other girls. As a result she was unable to concentrate on her studies. Finally, overwhelmed with shame and humiliation, both because of her poor academic work and the shatter-

ing of her youthful romance, she fled the campus for the solace of her home in rural Michigan.

She emphasized that the past was ancient history and begged for another opportunity. There was nothing to indicate that she could not do well, except the one semester at Michigan which had been a debacle. The psychiatrist, realizing that there were other universities in Michigan which were less intellectually demanding, gingerly pointed this out to her. She mulled this over briefly and replied, "There may be other schools in Michigan, but not for me!"

Decisions of this kind cannot be readily avoided, because refusal to make a decision is tantamount to having the student barred from enrollment or re-enrollment. The academic counselor, in effect, sought reassurance regarding the student's mental state and academic potential.

The gravity of the psychiatrist's responsibility is further emphasized by the fact that the course of a student's life can be permanently shaped by his decisions—and the student is stuck with that decision. Again, there is no parallel in private practice, where, even if one did venture to make a decision for a mentally competent patient, the patient remains free to reject or accept the decision as he sees fit.

ADMINISTRATOR-THERAPIST

The psychiatrist's primary obligation is to his patients. At a university health service, however, he is an officer of the university and, if not cautious, may soon come to regard himself as a university administrator rather than as a physician. When this occurs, the psychiatrist may no longer be able to serve his patients with the unbiased devotion that his work requires (2).

A recurring example of the administrator-therapist conflict is the problem posed by the student who previously suffered a psychotic breakdown on campus and wishes to re-enter the university (5). The psychiatrist may realize that there is a

strong possibility of another acute psychotic episode. On the other hand, he knows that the student has the potential for achieving his avowed goals and that it will do the student no harm to try. The effect of a rejection upon the student must also be taken into consideration.

It is difficult to remain objective when one admits two or three students with a past history of psychotic decompensation and they all promptly have another psychotic episode creating no little disturbance on campus. (It does not help matters, of course, when the person for whom they create the most discomfort is the psychiatrist who permitted their re-enrollment!)

Granted that an occasional decision of this magnitude will be made by any psychotherapist, it becomes a heavy burden when one has repeatedly to make such decisions each semester, as is often the case at a large university.

VOLUME

In the private practice of psychiatry, volume is usually no problem. When the psychiatrist is busy, he can refer new patients to a colleague or place them on a waiting list. When new referrals are slow in forthcoming, additional patients are indeed welcome. At many college health services, however, demand for mental health services can be quite overwhelming. A clinic confronted with this problem has a fundamental choice to make. It can follow certain private practice models, which means building up enormous waiting lists, with students waiting for months; it can see all patients immediately; or can attempt an approach falling between these.

At the University of Michigan, the second course has been pursued ever since the inception of the clinic, and all students are seen without undue delay (2). In ef-

fect, the result is that the majority of students can only be seen for a few interviews, at most, and the turnover is brisk. Although this approach can be helpful to large numbers of students, it also means that many students will be terminated prematurely, leaving some disappointed or angry. This is particularly true in dealing with a sophisticated student body conversant with the rules of psychoanalysis and who have been given to understand, rightly or wrongly, that psychotherapy may take months or years to achieve a desired result.

After a while the psychiatrist may find himself becoming defensive from having to explain constantly to students why they cannot be seen for more than a few interviews, even though their problems have not been resolved.

There are, however, other unfortunate results of high volume which are more serious. When there are more patients to be seen than can be adequately handled, the clinic administrator may curtail or abandon staff conferences and meetings in a misguided effort to increase interviews. Staff members become isolated from each other, and the meaningful exchange of ideas necessary for the maintenance and development of professional skills is curtailed. Isolation may also increase the already overworked therapist's anxieties and increase his tendency to select patients for psychotherapy who are peaceful and dependent, while avoiding patients who might prove troublesome. Stated another way, the therapist who is intellectually isolated from his colleagues may unconsciously seek solace and support from his patients, thus undermining therapeutic judgment and effectiveness (6).

Paradoxically, the longer one works at a health service mental hygiene unit, the more his volume problem compounds it-

self. As more students and staff get to know the therapist, the direct referrals build up into a veritable tidal wave. Soon the psychiatrist may find himself doing less and less for more and more people.

PASSING THE BUCK

When the health service psychiatrist has been on the job for a while, he gradually realizes that many difficult problems are passed to him, whether or not they are of a psychiatric nature. A number of campus officials will send the psychiatrist everything unusual that they are unable to resolve themselves. A few examples will serve to illustrate the point. (There is no intent to imply here that the students' requests were without merit.)

1. A foreign student, Lt. B, was first seen by the health service psychiatrist during the last week of the spring semester. He had been referred by a health service physician. Lt. B wanted help in obtaining a medical withdrawal from a difficult course because he felt he was not adequately prepared to take the final examination. He emphasized that he was an officer in his country's navy and that failure in the course could seriously blight his career.

He related that shortly after his arrival at the University of Michigan, he was summoned to the health service and informed that his entrance chest film revealed an abnormality. He was told there was a possibility that he had pulmonary tuberculosis and that he should "take it easy." He maintained that both as a result of taking it easy and his natural concern over the possibility of having tuberculosis, he had been unable to concentrate fully on his courses. He has been followed all semester in the general clinic of the health service and was finally told he did not have an active lesion.

He had fallen so far behind in one difficult course, however, that he felt he would fail the final examination if he had to take it. He had importuned the general physician who had followed him all semester to request his instructor to permit him to withdraw from the course on a medical basis. The physician was unable to resolve her own indecision regarding his request and referred him to the psychiatrist.

2. In the fall of 1957, the university community was struck by the influenza epidemic that swept the country. Mr. C was one of many students who contracted the ailment and quite early in the semester spent two weeks in the health service infirmary. Although he had never had serious academic difficulty before, he was not a brilliant student and the two-week handicap soon made itself apparent.

Toward the end of the semester, he realized that he could not pass all his courses. He felt that if he could drop one or two courses and concentrate on the others, he could salvage the semester. He went to a number of officials on campus about this, and after being passed around, was ultimately referred to the health service psychiatrist, despite the fact that he neither complained of nor suffered from any psychiatric problems.

As noted above, requests of this kind made by students may be valid, albeit non-psychiatric. Mr. D's case was quite similar and yet subtly psychological. Interestingly enough, he was *not* referred to the psychiatrist.

Mr. D, a senior in the School of Business Administration, came to the psychiatrist on his own after he had been denied relief elsewhere. During the prior summer recess he had traveled to a distant community to work for an advertising firm in order to gain experience. While taking an evening stroll, he was abruptly apprehended by two detectives, taken to the police station and there somewhat hesitantly indentified by two girls as an exhibitionist.

The evidence against him was dubious, and the defense chosen by his attorney was to gain a series of postponements in the hope that the case eventually would be dropped. However, since Mr. D had no way of knowing whether he would eventually be tried and convicted, he remained in a highly agitated state throughout the fall semester.

Late in the semester, he, too, sought relief by attempting to drop certain courses, presumably in an effort to concentrate on others. His requests were denied, and he ultimately came to the psychiatrist to obtain a recommendation for withdrawal from two courses because he felt there were valid reasons for his being unable to do optimal work during the semester.

EVALUATIONS AND CONFIDENTIALITY

The problem of evaluations or "screening" for various schools and agencies of a university may arise at any college mental hygiene clinic. However, any clinic that has treatment as its primary purpose should not be placed in a position where it has to render judgment on past, present or future patients. Students will quickly learn that the clinic is filing reports (even though it be only under special circumstances) with various administrative offices of the university.

This may undermine confidence in the clinic and result in students not coming for help even when they desperately need it, or displaying lack of candor when they do come. College mental hygiene clinics may be somewhat distrusted by the student body in any case, because they are part of the university. Any function of the clinic that does not have *treatment* as its primary goal serves only further to undermine student confidence. If judgmental mental health screening is necessary for such things as the granting of teaching certificates and entry into graduate school programs, it should not be done by health service personnel.

Sometimes the screening appeal made to a health service is, in reality, another form of "passing the buck." It is amazing how many persons cannot bring themselves to inform a student that he is not making the grade and must be dropped. Not infrequently they will try to inveigle the psychiatrist into serving as their "hatchet man" on the basis of the student's having an emotional disturbance.

Even when the clinic makes efforts to maintain confidentiality and steadfastly refuses to do screening for other components of the university, difficult situations re-

garding confidentiality occasionally arise to plague the therapist.

The following case illustrates how a dilemma of this kind may arise.

Mr. E, a 21-year-old senior, applied to medical school and received a routine medical school form to be filled out by a physician. Although he could have used a private physician, he chose to go to the general clinic of the health service. During the course of his physical examination, the physician examining him glanced at his medical chart and noted that he had previously been seen at the Mental Hygiene Clinic. He therefore refused to sign that part of the medical form which attested to the student's mental and emotional fitness. Instead, he referred Mr. E to the Mental Hygiene Clinic because he believed that the psychiatrist could better evaluate the information in the student's mental hygiene folder.

When Mr. E. explained the situation, the psychiatrist reviewed his mental hygiene file. The material indicated that the student's personality and behavior were such that he could only be considered an extremely poor risk for medical school. This presented the psychiatrist with a rather curious dilemma. He could hardly sign his name to the medical form indicating his belief that the student would make an exemplary medical student. Nor could he communicate anything of a negative nature to the medical school regarding the student since the material on the clinic chart was confidential and given voluntarily.

Another potential problem to be kept in mind is the question of *future* confidentiality. Certain students who come to the health service for emotional problems must be advised that they may later be placed in an awkward position as a result of having sought this kind of help while in college.

Let us say that a homosexual student who came for help subsequently applies for a position with a government agency. He may then be asked to state whether or not he has had psychiatric help. In order not to perjure himself, he answers this

question in the affirmative and must provide details as to when and where. He can then hardly refuse to sign a release form, thus making it possible for an investigator to visit or write the clinic and find out the details of his problem.

When I first began health service work and students would ask if they could be certain the material they divulged would be kept in strictest confidence, I was completely reassuring. However, I soon realized that some material in the charts could conceivably be used to the student's detriment if he ever wanted a job badly enough to sign the necessary release. Thenceforth, whenever certain students would raise the question of total confidentiality, I felt duty bound to outline the above possibility.

SUICIDE

In terms of frequency, the problem of suicide is probably no greater on the college campus than it is among other groups. The campus setting does complicate matters, however, because the student usually does not live in contact with close relatives who can be relied upon to observe the patient and maintain contact with the psychiatrist.

This often means that the psychiatrist must assume the role of a relative surrogate and take the initiative in keeping in touch with the seriously depressed student. Since this can be quite a task, particularly on a large campus characterized by an infinite variety of widely scattered housing units, it behooves the campus psychiatrist to develop criteria to determine who is seriously suicidal and who is not.

Recent articles which stress the fact that the suicidal individual will communicate his suicidal intent (4) are of dubious value because of the large number of stu-

dents who casually speak of self-destruction, but who have absolutely no intention of doing anything injurious. The following statements were made in an off-hand manner by different students at the health service, who, I am certain, had no intention of harming themselves. "It would be a lot easier if I were quietly exterminated." "I just wish that a car would run over me." "I feel that I don't particularly want to live." Although I have no data as to what percentage of all students currently treated actually mention suicide, some documentation is available. Raphael and his associates noted that 5 per cent of all students seen at the Mental Hygiene Unit of the University of Michigan over a five-year period mentioned suicide (3).

How does one determine which statements to take seriously and which to ignore? There obviously cannot be a simple answer to this question. There are a few clues, however. The nonsuicidal student who mentions suicide will rarely make the statement as a direct declaration of intent; i.e., "It would be a lot easier if I were quietly exterminated." The statement is complaints about social or academic difficulties or failure to obtain gratification in various situations, and the patient does not dwell upon the subject.

The student who is severely depressed and emotionally isolated, however, does not merely content himself with casually mentioning extermination or a fatal accident, while going on to another subject. He is apt to dwell at some length on the subject of depression, hopelessness or suicide, and the listener will be impressed with the genuineness of the suffering that he sees before him. An example of statements made by two very sick and definitely suicidal students, both of whom required

hospitalization, follows. Note how much more intensive and extensive they are than the previous quotations.

1. "I just feel that I don't particularly want to live. I get into such a turmoil. I feel I would like to go to bed and never wake up. I am tired of feeling this way. I've been depressed for as long as I can remember. I've always felt that I would never be happy. I worry, worry, about everything. I constantly need something to do. I am constantly in a turmoil. I can't be alone for an evening. I am always calling someone, running around and in a frenzy."
2. "I get so depressed; then I think 'what is the use of going on?' I used to feel that way occasionally, but now it's a feeling that almost never leaves me. I can't see how I will ever be any different."

The thing that impresses one most about students who actually attempt suicide is their emotional isolation and loneliness. On a campus bubbling over with all kinds of activity, these young men and women are as isolated as if they were standing alone on a mountain top. Their inability to establish any kind of meaningful contact with others, particularly in an environment where they feel everyone else can do so, precipitates, or more likely accentuates, feelings of darkest despair. The suicidal attempt then follows.

If there is any one factor that may separate the potential suicide from the individual who speaks of suicide but who will not carry it out, it is the lack of gratifying and meaningful object relations in the past and present of the suicidal student.

SUMMARY

A number of unique professional challenges confront the college health service psychiatrist. These include the internal conflict inherent in the dual role of psy-

chiatrist and university administrator; the frequent necessity for making decisions about students which vitally affect the course of students' lives; the problem of "buck passing," wherein the psychiatrist may be forced to render decisions on matters nonpsychiatric; and the difficulties of maintaining contact with the potentially suicidal student despite impediments imposed by the campus setting.

Since substantial numbers of college students are apt to request psychological help, the problem of seeing more patients than can be adequately treated is omnipresent. The practice of screening for other components of the university may prove detrimental to the therapeutic goals of the mental hygiene clinic by undermining student confidence in the clinic.

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BENJAMIN MALZBERG, PH.D.

Mental disease among German-born and native whites of German parentage in New York State, 1949-1951

PART I

Born in Germany

According to the census of 1920, there were 295,650 foreign-born in New York State who were born in Germany.¹ According to the census of 1950, there were 270,661,² a reduction of 24,989. There is a possibility of error in classification—owing to changes in political boundaries—but this must be negligible when compared to the reduction due to restriction of immigration to the United States since 1920. In 1950, German-born still represented the third largest contingent of foreign-born in New York State.

The decennial census of population gives limited information with respect to the racial composition of the general population. The great division is between white and non-white. The foreign white population is defined by nativity. Some of these populations—for example, those born in

Norway, Sweden, Ireland, Italy—are sufficiently homogeneous to be treated as ethnic unities.

Those born in Germany do not possess the same degree of homogeneity. Nevertheless, there is reason for postulating a certain physical uniformity. There are no data with respect to German-born in New York State which permit a rigorous

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This is the sixth of a series of eight studies describing the frequency of mental disease among ethnic and national groups in the United States.

¹ *United States Census of Population, 1950. General Characteristics.* New York (Washington, D.C.: U. S. Government Printing Office, 1952), P-B 32, p. 64.

² *Ibid.*

verification of this statement. But some information is available, if one considers first admissions to mental hospitals in New York State.

It has been customary to describe such admissions ethnically, in accordance with definitions set up by the United States Immigration Commission.³ According to these criteria, 80 per cent of the first admissions during 1949-1951, who were born in Germany, were considered as German on an ethnic basis. If we accept this as an approximate distribution of the German-born population of New York State, we may assume a sufficient degree of homogeneity, which permits an analysis of the frequency of mental disease on an ethnic basis.

Whether emigrants are a representative sample of a population is subject to question. During the nineteenth century, there were factors which resulted at times in a good selection, and at other times in a poor selection. Since these cannot be evaluated at present, we shall not attempt to compare the incidence of mental disease among the German-born population of New York State with that of Germany.

Furthermore, the level of admissions to mental hospitals varies from one country

to another, chiefly because of historical attitudes toward the hospitalization of the mentally ill. Hence, international data do not furnish a good basis for comparisons of relative incidence of mental disease. For these reasons, generalizations of the results of the following study of mental disease among German-born will be limited to New York State.

Early census reports relating to patients admitted to hospitals for the mentally ill in the United States presented conflicting evidence with respect to German-born. The report for 1904 stated that "Germans constituted 25.8 per cent of all foreign-born in the United States in 1900, and constituted 26.9 per cent of all foreign-born white insane in hospitals in 1903."⁴

The report for 1910 stated that German-born had a total admission rate of 127.7 per 100,000, whereas all foreign-born had a rate of 116.3.⁵ The rate for total whites was 68.7.⁶

The report for 1923 showed a lower rate of first admissions for German-born than for all foreign-born, the rates being 104.9 and 113.2 per 100,000, respectively, in 1922.⁷ Both exceeded the rate for the total white population, 69.5.⁸

However, these are all crude rates, and even if they had been in accord, a more detailed analysis would still be necessary. Such an analysis is presented, therefore, in the following study, which is based upon statistics of first admissions among German-born to all hospitals for mental disease in New York State from October 1, 1948, to September 30, 1951. This period was selected because the midpoint, April 1, 1950, coincided with the date of the census of population, and thus permitted the computation of annual rates of first admissions.

There were 1,777 German-born first admissions to these hospitals during the three

³ *Reports of the Immigration Commission. Dictionary of Races or Peoples.* 61st Congress, 3rd Session. U. S. Senate Document No. 662.

⁴ *Insane and Feeble-minded in Hospitals and Institutions* (Washington, D.C.: Bureau of the Census, 1906), p. 24.

⁵ *Insane and Feeble-minded in Institutions* (Washington, D.C.: Bureau of the Census, 1914), p. 31.

⁶ *Ibid.*, p. 117.

⁷ *Patients in Hospitals for Mental Disease, 1923* (Washington, D.C.: Bureau of the Census, 1926), p. 25.

⁸ *Ibid.*, p. 117.

years. The leading diagnostic categories were senile psychoses, with 526 first admissions, or 29.6 per cent of the total, and psychoses with cerebral arteriosclerosis, with a total of 500, or 28.1 per cent. General paresis and alcoholic psychoses had small totals, including only 16 and 46 cases, respectively.

The native white population differed significantly from the preceding with respect to the relative order of the psychoses. Dementia praecox included 33.0 per cent of the total native white first admissions. On the other hand, psychoses with cerebral arteriosclerosis and senile psychoses included only 14.9 and 10.4 per cent, respectively.

These differences originated in the age distributions of the two populations. German-born had a median age of 52.7 years. Those aged 65 and over included 26.9 per cent of the total, and 18.5 per cent were under age 40. Native whites, however, had a median age of only 29.0 years; 6.0 per cent were aged 65 and over, but 68.9 per cent were under age 40. The older age proportions of the German-born nec-

essarily raised the level of senile and arteriosclerotic mental disorders, whereas the younger ages of the native whites raised the proportion of first admissions with dementia praecox.

Table 1 also includes average annual rates of first admissions per 100,000 population. The differences are apparent. The rates for psychoses with cerebral arteriosclerosis were 61.6 for German-born and 15.4 for native whites. Corresponding rates for senile psychoses were 64.8 and 10.8, respectively. On the other hand, native whites had a rate of 34.3 for dementia praecox, compared with 31.8 for German-born. The rates for all first admissions were 218.8 per 100,000 German-born, and 103.9 for native whites, a ratio of 2.11 to 1.

In general, average annual rates of first admissions among native whites, classified according to age, increased steadily with advancing age to a maximum of 705.7 per 100,000 at ages 75 and over. In order to compute similar rates for German-born, it was necessary to have the age distribution of the population of German birth, liv-

TABLE 1

First admissions, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to mental disorders

Mental disorders	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	9	7	16	1.1	0.7	0.9	2.3	1.6	2.0
Alcoholic	39	7	46	4.9	0.7	2.6	10.1	1.6	5.7
With cerebral arteriosclerosis	276	224	500	34.6	22.9	28.1	71.2	52.8	61.6
Senile	201	325	526	25.2	33.2	29.6	51.9	76.6	64.8
Involuntional	53	148	201	6.6	15.1	11.3	13.7	34.9	24.8
Manic-depressive	15	37	52	1.9	3.8	2.9	3.9	8.7	6.4
Dementia praecox	107	151	258	13.4	15.4	14.5	27.6	35.6	31.8
Other	98	80	178	12.3	8.2	10.0	25.3	18.8	21.9
Total	798	979	1,777	100.0	100.0	100.0	205.9	230.6	218.8

ing in New York State. These data were not available for German-born in New York State in 1950, but they were estimated as follows.

The Middle Atlantic Division, which includes New York, New Jersey and Pennsylvania, had a German-born population of 406,605 on April 1, 1950.⁹ Of this total, 270,661, or 66.6 per cent, were living in New York State.¹⁰ Because of this large percentage, we assumed that the German-born in New York State had the same age and sex proportions as the total German-born in the Middle Atlantic Division.¹¹ On this basis, age-specific rates of first admissions were computed, and are shown in Table 2.

On the basis of crude rates, the average annual rate for native whites was only 47 per cent of that for German-born. However, age-specific rates for native whites were in excess of those for German-born

between ages 40 and 69. At other ages they had lower rates, but these ranged from 70 to 90 per cent of corresponding rates for German-born. There was a sex difference. In general, native white females had lower age-specific rates than German-born females.

The large difference in crude rates was, therefore, an artifact of the age structures of the two populations. The rates were therefore adjusted by using as standard the white population of New York State in age and sex proportions as of April 1, 1950. (See Table 3.)

The standardized rates were 169.4 per

⁹ *United States Census of Population, 1950. Nativity and Parentage* (Washington, D.C.: Government Printing Office, 1952). Report P-E, No. 3A, p. 95.

¹⁰ *Ibid.*, p. 77.

¹¹ Computed from data in footnote 9 p. 95.

TABLE 2

First admissions, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 15	1	..	1	0.1	..	0.1	9.1	..	4.6
15-19	6	8	14	0.8	0.8	0.8	149.9	189.0	170.0
20-24	13	16	29	1.6	1.6	1.6	174.7	121.4	140.7
25-29	26	30	56	3.3	3.1	3.2	173.4	154.4	162.7
30-34	7	22	29	0.9	2.2	1.6	69.9	176.2	128.9
35-39	26	37	63	3.3	3.8	3.5	139.4	155.3	148.3
40-44	40	60	100	5.0	6.1	5.6	85.1	129.4	107.1
45-49	55	83	138	6.9	8.5	7.8	92.1	154.1	121.4
50-54	49	55	104	6.1	5.6	5.9	107.4	120.7	114.1
55-59	33	60	93	4.1	6.1	5.2	92.0	164.2	128.4
60-64	52	60	112	6.5	6.1	6.3	142.6	165.8	154.1
65-69	76	55	131	9.5	5.6	7.4	237.8	152.7	192.7
70-74	122	119	241	15.3	12.2	13.6	430.7	335.2	377.5
75 and over	291	374	665	36.4	38.2	37.4	798.0	743.8	766.6
Unascertained	1	..	1	0.1	..	0.1	..	..	..
Total	798	979	1,777	100.0	100.0	100.0	205.9	230.6	218.8

TABLE 3

*Average annual standardized * rates of first admissions to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among German-born and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	157.3±7.54	1.00	175.5±7.60	1.24	169.4±5.40	1.11
All foreign-born	168.2±2.50	1.07	180.5±2.57	1.27	178.7±1.82	1.18
Native	157.1±1.35	1.00	141.8±1.22	1.00	152.0±0.91	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

100,000 for German-born and 152.0 for native whites. On the basis of crude rates, German-born were in excess by 110 per cent. Adjustments for age differences reduced the excess to only 11 per cent. The excess resulted almost entirely from a relatively high rate of 175.5 among German-born females, compared with a rate of 141.8 for native white females. The difference in rates between German-born and all foreign-born whites was not statistically significant.

In addition to age, rates of first admissions are influenced by the urban-rural distribution of the population. Unfortunately, such a comparison cannot be made, because the definitions of urban-rural employed by the mental hospitals differed from that introduced by the Bureau of the Census in 1950. Therefore, as an approximation to standardization according to environment, we shall compare rates of first admissions from New York City. This is of importance since 69 per cent of the German-born in New York State were living in New York City on April 1, 1950, compared with only 47 per cent of native whites.

Standardizing the rates for New York City required an age distribution of the

German-born and of native whites. The latter was available from the census of April 1, 1950,¹² but, as for the entire state, corresponding data were not available for German-born living in New York City. We therefore assumed that their age and sex proportions were the same as those for the urban part of the Middle Atlantic Division.¹³ More than half of the urbanized German-born in this division were living in New York City on April 1, 1950. Therefore, our assumption appears reasonable.

Rates of first admissions for New York City were standardized on the same basis as those for New York State.

The standardized rates, per 100,000 population, were 185.4 for German-born and 168.8 for native whites. Both exceeded the corresponding rates for the state, but the excess of the rate for the former was only 10 per cent. The rates for German-born and all foreign-born whites did not differ significantly.

We may conclude that German-born had a higher rate of first admissions than native whites, but that larger numbers are neces-

¹² *Ibid.*, p. 35.

¹³ *Ibid.*, p. 95.

sary to substantiate the significance of the difference.

Alcoholic Psychoses

There were 46 German-born first admissions with alcoholic psychoses during 1949-1951, or an average annual rate of 5.7 per 100,000. Native whites had a corresponding rate of 5.8. The rate for German-born was influenced by the fact that 50 per cent were in the primary age range for this disorder, 35 to 59, compared with 30 per cent of the native whites.

The rates were therefore standardized to take account of this difference. (See Table 5.)

With adjustments for age, it became evident that German-born had a significantly lower rate of alcoholic psychoses than native whites. The average annual standardized rates per 100,000 were 5.1 for German-born and 9.9 for native whites,

the latter being in excess in the ratio of 1.94 to 1. Although German-born males and females both had lower rates than the corresponding native populations, the difference was especially notable among females. German-born had lower standardized rates than all foreign-born whites, although the differences are not statistically significant.

As with general paresis, the incidence of alcoholic psychoses is influenced strongly by the proportion of the population living in urban areas. Because of limitations explained previously, such a comparison must be restricted to New York City. Because of the concentration of German-born in that city, we are afforded an approximation to a comparison on the basis of a more equivalent environment for native and foreign-born.

German-born living in New York City had an average annual standardized rate

TABLE 4

First admissions with alcoholic psychoses, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 20	..	..	..	..	..	..	..	..	..
20-24	..	..	..	..	..	..	..	..	..
25-29	..	..	..	..	..	..	..	..	..
30-34	..	..	..	..	..	..	..	..	..
35-39	4	..	4	10.3	..	8.7	21.4	..	9.4
40-44	6	1	7	15.4	14.3	15.2	12.8	2.2	7.5
45-49	7	3	10	17.9	42.9	21.7	11.7	5.6	8.8
50-54	7	..	7	17.9	..	15.2	15.4	..	7.9
55-59	5	1	6	12.8	14.3	13.0	13.9	2.7	8.3
60-64	6	1	7	15.4	14.3	15.2	16.4	2.8	9.6
65-69	3	1	4	7.7	14.3	8.7	9.4	2.8	5.9
70-74	..	..	..	..	..	..	..	..	..
75 and over	1	..	1	2.6	..	2.2	2.7	..	1.2
Total	39	7	46	100.0	100.0	100.0	10.1	1.6	5.7

TABLE 5

*Average annual standardized * rates of first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among German-born and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	9.2±1.84	0.56	1.4±0.67	0.35	5.1±0.94	0.52
All foreign-born	11.7±0.66	0.71	3.4±0.35	0.85	7.4±0.37	0.74
Native	16.4±0.46	1.00	4.0±0.22	1.00	9.9±0.24	1.00

* White population of New York State aged 20 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

of 4.8 per 100,000, compared with 11.3 for native whites. The relative difference between the two populations was therefore increased. The rate for German-born females was especially low.

We may therefore conclude that the incidence of alcoholic psychoses among German-born is less than that for all foreign-born whites, and is significantly less than that for native whites.

Psychoses with Cerebral Arteriosclerosis

There were 500 German-born first admissions with psychoses with cerebral arteriosclerosis, or an average annual rate of 61.6 per 100,000.

Native whites had a corresponding rate of only 15.4. The large difference was due to the fact that 27 per cent of the German-born were aged 65 and over, compared with only 6 per cent of the native-born. It is essential, therefore, that the rates be standardized. (See Table 7.)

On the basis of crude rates, the German-born were in excess by 300 per cent. When standardized, however, the rates became 61.1 per 100,000 for German-born and 68.8 for native whites. Instead of an excess, the German-born had a lower rate, al-

though the difference is not statistically significant. It may also be noted that, in contrast to German-born, all foreign-born whites had a higher rate than native whites.

A further correction must be made with respect to concentration of population, the incidence of psychoses with cerebral arteriosclerosis being higher in urban areas.¹⁴

As an approximation to this factor, we present standardized rates of first admissions for New York City. German-born, living in New York City, had an average annual standardized rate of 61.2 per 100,000, compared with 83.2 for native whites. The rate was notably low for German-born females. We may also note that German-born had a lower rate than all foreign-born whites. Rates for the latter did not differ significantly when compared with native whites.

Senile Psychoses

There were 526 first admissions with senile psychoses during 1949-1951, or an

¹⁴ See Malzberg, Benjamin, "The Distribution of Mental Diseases in New York State, 1949-1951," *Psychiatric Quarterly Supplement*, 29(Part 2, 1955), 220.

TABLE 6

First admissions with psychoses with cerebral arteriosclerosis, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 40	..	..	..	..	..	..	..	..	..
40-44	..	..	..	..	..	..	..	..	..
45-49	..	..	..	..	..	..	..	..	..
50-54	3	2	5	1.1	0.9	1.0	6.6	4.4	5.4
55-59	4	5	9	1.5	2.2	1.8	11.2	13.7	12.4
60-64	18	21	39	6.5	9.4	7.8	49.4	58.0	53.7
65-69	47	29	76	17.0	12.9	15.2	147.1	80.5	111.8
70-74	74	54	128	26.8	24.1	25.6	261.2	152.1	200.5
75 and over	129	113	242	46.7	50.4	48.4	353.7	224.7	279.0
Unascertained	1	..	1	0.4	..	0.2	..	..	..
Total	276	224	500	100.0	100.0	100.0	71.2	52.8	61.6

average annual rate of 64.8 per 100,000 population. Native whites had a corresponding rate of 10.8, the former being in excess in the ratio of 6.0 to 1.

As with other disorders associated with advanced age, the difference was due to the disproportionate number of German-born at older ages. Standardized rates are therefore shown in Table 9.

German-born had a standardized rate of 52.4 per 100,000, compared with 46.0 for native whites. The excess amounted to 14 per cent, compared to an excess of 500 per cent on the basis of crude rates.

But the difference is still spurious because the rates are influenced by the proportion of the populations living in dense, urban areas. We may compensate for the

TABLE 7

*Average annual standardized * rates of first admissions with psychoses with cerebral arteriosclerosis, to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among German-born and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	70.0±5.90	0.93	47.3±4.68	0.84	61.1±3.83	0.89
All foreign-born	78.7±1.95	1.04	66.3±1.82	1.18	76.3±1.37	1.11
Native	75.4±0.74	1.00	56.0±1.33	1.00	68.8±1.08	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

effect of such concentration by limiting the comparisons to New York City.

We now find that German-born had a lower rate than native whites, the standardized rates being 49.7 and 64.9 per 100,000, respectively. The difference, 15.2, is statistically significant. We may also note that German-born had a lower rate than all foreign-born whites. The rate for the latter did not differ significantly from that for native whites.

Involucional Psychoses

There were 201 German-born first ad-

respect to age and sex proportions, and are summarized in Table 11.

The standardized rates per 100,000 population were 29.3 for German-born and 21.4 for native whites. The excess was only 37 per cent, compared with 214 per cent on the basis of crude rates. There was no significant difference among males, but German-born females had a significantly higher rate.

The difference in rates was narrowed still further by considering the gross environmental factor, and restricting comparisons to New York City.

TABLE 8

First admissions with senile psychoses, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 50	..	..	..	..	..	..	..	..	..
50-54	..	..	..	..	..	..	..	..	..
55-59	..	..	..	..	..	..	..	..	..
60-64	2	2	4	1.0	0.6	0.8	5.4	5.5	5.5
65-69	4	13	17	2.0	4.0	3.2	12.5	36.1	25.0
70-74	39	52	91	19.4	16.0	17.3	137.7	146.4	142.6
75 and over	156	258	414	77.6	79.4	78.7	427.8	513.1	477.2
Total	201	325	526	100.0	100.0	100.0	51.9	76.6	64.8

missions with involutional psychoses during 1949-1951, or an average annual rate of 24.8 per 100,000. Native whites had a corresponding rate of 7.9. The former was in excess in the ratio of 3.14 to 1. This was due, in part, to differences in age composition.

The age range of involutional psychoses is predominantly from 35 to 64. This interval included 60 per cent of the German-born, but only 33 per cent of native whites. The rates were therefore adjusted with

Standardized rates of first admissions from New York City were 30.2 per 100,000 for German-born, and 24.6 for native whites. The former was in excess by 23 per cent. German-born males had a lower rate than native males, although the difference was not significant.

Dementia Praecox

There were 258 German-born first admissions with dementia praecox during 1949-1951, giving an average annual rate

TABLE 9

Average annual standardized rates of first admissions with senile psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among German-born and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	41.9±4.57	1.15	51.1±4.87	1.16	52.4±3.54	1.14
All foreign-born	44.8±1.48	1.23	59.4±1.72	1.34	59.9±1.28	1.30
Native	36.4±1.14	1.00	44.2±1.18	1.00	46.0±0.88	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

of 31.8 per 100,000. Native whites had a corresponding rate of 34.3.

The rate for the former was spuriously low, however, because of the age factor. When the rates were adjusted with respect to age, a significant difference developed between the two. (See Table 13.)

German-born had a standardized rate of

58.2 per 100,000, compared with 41.3 for native whites, the former being in excess by 41 per cent.

Limiting the comparisons to populations living in New York City did not change the relative order of the rates significantly. German-born, living in New York City, had a standardized rate of 66.1

TABLE 10

First admissions with involutional psychoses, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 30	..	..	..	..	..	..	..	..	..
30-34	..	1	1	..	0.7	0.5	..	8.0	4.4
35-39	..	1	1	..	0.7	0.5	..	4.2	2.4
40-44	2	18	20	3.8	12.2	10.0	4.3	38.8	21.4
45-49	12	41	53	22.6	27.7	26.4	20.1	76.1	46.7
50-54	13	32	45	24.5	21.6	22.4	28.5	70.3	49.4
55-59	9	32	41	17.0	21.6	20.4	25.1	87.6	56.6
60-64	9	16	25	17.0	10.8	12.4	24.7	44.2	34.4
65-69	8	5	13	15.1	3.4	6.4	25.0	13.9	19.1
70-74	..	2	2	..	1.4	1.0	..	5.6	3.1
75 and over	..	..	..	..	..	..	..	..	..
Total	53	148	201	100.0	100.0	100.0	13.7	34.9	24.8

TABLE 11

*Average annual standardized * rates of first admissions with involuntional psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among German-born and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	15.1±2.46	1.04	44.4±4.08	1.55	29.3±2.38	1.57
All foreign-born	17.9±0.86	1.24	42.0±1.31	1.44	29.5±0.78	1.38
Native	14.4±0.56	1.00	29.0±0.74	1.00	21.4±0.47	1.00

* White population of New York State aged 35 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

per 100,000, compared with 48.9 for native whites. German-born also had higher rates than all foreign-born whites.

It is evident, therefore, that German-born had a relatively high rate of dementia praecox.

PART II

Native-born of German Parentage

The United States Bureau of the Census defines foreign white stock as those of foreign birth or native-born of foreign parentage. The latter include natives of mixed parentage; that is, one parent native, the other foreign-born. Thus, with respect to Germans, the second generation of German stock in New York State is defined as native-born with both parents born in Germany, or one parent born in the United States, the other in Germany. It also includes natives with both parents foreign-born, but the father born in Germany.

On this basis, there were 495,295 native whites of German parentage in New York State on April 1, 1950, the third largest population of foreign parentage in the state.¹⁵ The degree of ethnic homogeneity cannot be specified accurately. There is

probably less homogeneity than is found among other populations of foreign parentage in New York, such as Scandinavians, or Italians.

Nevertheless, a high degree of ethnic unity may be considered probable in both generations of German origin in New York State, because marriage within the first generation, at least, may be assumed to be largely on the basis of assortative mating; that is, the partners are both likely to be of the same origin. Some support for this inference is found in the fact that, of the 2,541 native-white first admissions whose parents were born in Germany, 60 per cent had parents who were both born in Germany. In another 25 per cent, one parent was born in Germany, and was considered of German ethnic stock.

For practical purposes, therefore, German-born and natives of German parentage may be considered as belonging to a common stock. Differences between them in the incidence of mental disease, therefore, suggest the influence of social and other environmental factors.

There were 2,541 native first admissions of German parentage to all hospitals for

¹⁵ See footnote 1, p. 77.

mental disease in New York State during 1949-1951.

Of the total, 707, or 27.8 per cent, were classified as psychoses with cerebral arteriosclerosis, and 577, or 22.7 per cent, were senile psychoses. Together they included 50.5 per cent of the total first admissions. Dementia praecox included 373 first admissions, or 14.7 per cent. This was followed closely by involutional psychoses with 313 cases, or 12.3 per cent.

Unlike other populations—Italians, for example—this distribution did not differ significantly from that for German-born first admissions. Among the latter, the leading groups of psychoses were distributed as follows: psychoses with cerebral arteriosclerosis, 28.1 per cent of the total; senile psychoses, 29.6 per cent; dementia praecox, 14.5 per cent. The similarity in distribution is due to the fact that the

population of German origin has a long history in New York State, so that even the second generation includes a relatively high percentage at advanced age. Thus, the median age for German-born was 52.7 years, and natives of German parentage had a median age of 50.1 years.

The two differ with respect to crude rates of first admissions, however. Thus, natives of German parentage had an average annual rate (all first admissions) of 171.0 per 100,000, compared with 218.8 for German-born. Rates for psychoses with cerebral arteriosclerosis were 47.6 and 61.6, respectively. Rates for senile psychoses were 38.8 and 64.8, respectively. For dementia praecox, they were 25.1 and 31.8, respectively.

As compared with natives of native parentage, those of German parentage had higher rates of psychoses associated with

TABLE 12

First admissions with dementia praecox, born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	..	..	..	..	..	..	..	..	..
10-14	1	..	1	0.9	..	0.4	49.3	..	24.9
15-19	4	6	10	3.7	4.0	3.9	100.0	108.4	121.4
20-24	9	10	19	8.4	6.6	7.4	121.0	75.9	92.2
25-29	23	18	41	21.5	11.9	15.9	153.4	93.0	119.1
30-34	6	10	16	5.6	6.6	6.2	59.9	80.1	71.1
35-39	16	21	37	15.0	13.9	14.3	85.8	88.1	87.1
40-44	19	33	52	17.8	21.9	20.2	40.4	71.2	55.7
45-49	16	20	36	15.0	13.2	14.0	26.8	37.1	31.7
50-54	6	12	18	5.6	7.9	7.0	13.2	26.3	19.7
55-59	2	10	12	1.9	6.6	4.7	5.6	27.4	16.6
60-64	3	8	11	2.8	5.3	4.3	8.2	22.1	15.1
65-69	2	..	2	1.9	..	0.8	6.3	..	2.9
70-74	..	2	2	..	1.3	0.8	..	5.6	3.1
75 and over	..	1	1	..	0.7	0.4	..	2.0	1.2
Total	107	151	258	100.0	100.0	100.0	27.6	35.6	31.8

TABLE 13

*Average annual standardized * rates of first admissions with dementia praecox to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among German-born and selected nativity groups*

Nativity	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	58.0±4.59	1.39	58.3±4.38	1.44	58.2±3.17	1.41
All foreign-born	57.2±1.46	1.37	50.3±1.36	1.24	52.7±0.99	1.28
Native	41.8±0.70	1.00	40.6±0.65	1.00	41.3±0.48	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

advanced age, but a lower rate of first admissions with dementia praecox.

Such differences are obviously due to the varying age structures of the populations. A more legitimate comparison is with respect to age-specific rates of first admissions. These may be computed for native whites of native parentage from the data provided by the census of 1950,

and from the statistics of first admissions. But similar distributions by age and sex are not available by individual states for German-born and natives of German parentage. The data for German-born were computed in the manner explained in a previous section.

An approximation for natives of German parentage was obtained by assuming the

TABLE 14

Native-white first admissions, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to mental disorders

Mental disorders	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	19	12	31	1.7	0.8	1.2	2.7	1.5	2.1
Alcoholic	103	18	121	9.3	1.3	4.8	14.8	2.3	8.1
With cerebral arteriosclerosis	351	356	707	31.7	24.8	27.8	50.6	45.0	47.6
Senile	196	381	577	17.7	26.6	22.7	28.2	48.1	38.8
Involuntional	92	221	313	8.3	15.4	12.3	13.3	27.9	21.1
Manic-depressive	18	65	83	1.6	4.5	3.3	2.6	8.2	5.6
Dementia praecox	164	209	373	14.8	14.6	14.7	23.6	26.4	25.1
Other	164	172	336	14.8	12.0	13.2	23.6	21.7	22.6
Total	1,107	1,434	2,541	100.0	100.0	100.0	159.4	181.1	171.0

same age and sex distribution as for natives of German parentage living in the Middle Atlantic division on April 1, 1950.¹⁸ There was a total of 923,575 of such nativity and parentage in the division, of whom 54 per cent were living in New York. There is no reason for assuming that the age composition of natives of German parentage living in New Jersey and Pennsylvania differed significantly from that for New York. On this basis, age-specific rates were computed for natives of German parentage in New York State, as shown in Table 15.

Despite some fluctuations, it is clear that the rates increased with advancing age to a maximum of 739.4 per 100,000 at age 75 and over. Rates for German-born increased to a maximum of 766.6. Rates for native whites of native parentage were at

a lower level and increased to a maximum of 497.1.

On the basis of crude rates, natives of German parentage had a rate equal to only 78 per cent of that for German-born. In general, the second generation had lower rates at corresponding ages, but there was greater equality between the rates. Native males of German parentage, in fact, had higher rates than German-born males between ages 40 and 64.

A similar comparison may be made between natives of native parentage and natives of German parentage. The effect of age is clear. Thus, the crude rate for natives of native parentage was only 45 per cent of that for those of German parentage. At corresponding ages, however, the rates were much closer to each other; and among males, rates for those of native

TABLE 15

Native-white first admissions, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	2	..	2	0.2	..	0.1	4.7	..	2.3
10-14	2	1	3	0.2	0.1	0.1	8.6	4.7	6.7
15-19	12	19	31	1.1	1.3	1.2	50.7	77.6	64.4
20-24	30	21	51	2.7	1.4	2.0	124.3	77.9	99.8
25-29	41	33	74	3.7	2.3	2.9	162.7	120.4	140.7
30-34	31	48	79	2.8	3.3	3.1	85.6	117.6	102.5
35-39	42	57	99	3.8	4.0	3.9	84.1	107.3	96.0
40-44	61	87	148	5.5	6.1	5.8	97.0	130.4	114.3
45-49	73	91	164	6.6	6.3	6.4	102.4	119.2	111.1
50-54	89	134	223	8.0	9.4	8.8	110.6	152.3	132.4
55-59	104	105	209	9.4	7.3	8.2	136.0	122.1	128.6
60-64	105	103	208	9.5	7.2	8.2	167.9	139.6	152.6
65-69	101	132	233	9.1	9.2	9.2	225.6	221.1	223.0
70-74	132	167	299	11.9	11.6	11.8	397.6	370.4	381.9
75 and over	282	436	718	25.4	30.4	28.3	756.1	729.1	739.4
Total	1,107	1,434	2,541	100.0	100.0	100.0	159.4	181.1	171.0

¹⁸ *Ibid.*, p. 95.

parentage were in excess between ages 30 and 54.

It is therefore necessary to adjust the summary rates with respect to the variations in sex and age proportions. The rates were standardized and summarized in Table 16.

Natives of German parentage had a standardized rate of 152.4 per 100,000, compared with 169.4 for German-born. The disparity was marked among females. Natives of German parentage also had significantly lower rates than all natives

it was the same as that for natives of German parentage living in the urban area of the Middle Atlantic division. Age-specific rates were computed and used in standardizing rates of first admissions from New York City.

Natives of German parentage had a rate of 145.3 per 100,000, compared with 185.4 for German-born. The former also had a significantly lower rate than all natives of foreign parentage. But they had higher rates than natives of native parentage, although the excess amounted to only 4

TABLE 16

*Average annual standardized * rates of first admissions to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of German parentage and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	144.2±5.59	1.14	147.2±5.24	1.27	152.4±3.91	1.24
All foreign-born	201.9±2.28	1.59	177.0±2.03	1.52	197.8±1.56	1.61
Native	126.9±1.64	1.00	116.3±1.49	1.00	123.2±1.11	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

of foreign parentage. Natives of German parentage had a higher standardized rate than natives of native parentage, the former being in excess by 24 per cent, a marked reduction from the excess shown by crude rates.

It is necessary to make a further comparison with respect to the urban-rural ratios of the several populations. For reasons explained previously, it is necessary to limit the comparisons to New York City. A preliminary requirement was the age and sex distribution of natives of German parentage, living in New York City. This was obtained by assuming that

per cent among males, and to 24 per cent among females.

It is evident, therefore, that natives of German parentage had a lower rate than all natives of foreign parentage, but a higher rate than natives of native parentage. The reduction in rates between first and second-generation Germans in New York State and City was significant.

Alcoholic Psychoses

There were 121 first admissions with alcoholic psychoses among natives of German parentage during 1949-1951, or an

TABLE 17

Native-white first admissions with alcoholic psychoses, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 20	..	..	..	..	..	..	..	..	..
20-24	..	..	..	..	..	..	..	..	..
25-29	1	..	1	1.0	..	0.8	11.9	..	1.9
30-34	3	..	3	2.9	..	2.4	24.9	..	3.9
35-39	3	1	4	2.9	5.6	3.3	6.0	1.9	3.9
40-44	13	7	20	12.6	38.9	16.5	20.7	10.5	15.4
45-49	11	3	14	10.7	16.7	11.6	15.4	3.9	9.5
50-54	17	1	18	16.5	5.6	14.9	21.1	1.1	10.7
55-59	19	3	22	18.4	16.7	18.2	24.8	3.4	13.5
60-64	22	3	25	21.4	16.7	20.7	35.2	4.1	18.3
65-69	11	..	11	10.7	..	9.1	24.6	..	10.5
70-74	2	..	2	1.9	..	1.7	6.0	..	2.6
75 and over	1	..	1	1.0	..	0.8	2.7	..	1.0
Total	103	18	121	100.0	100.0	100.0	14.8	2.3	8.1

average annual rate of 8.1 per 100,000. German-born had a rate of 5.7. Natives of native parentage had a rate of 4.4.

As with general paresis, these crude rates are influenced by the age distributions of the several populations. The rates were

therefore standardized, and are shown in Table 18.

Natives of German parentage had a standardized rate of 9.2 per 100,000, compared with 5.1 for German-born. Native males and females of German parentage

TABLE 18

*Average annual standardized * rates of first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of German parentage and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	16.5±1.93	1.19	2.4±0.68	0.69	9.2±0.98	1.10
All foreign-born	19.9±0.74	1.43	4.6±0.34	1.31	11.9±0.40	1.42
Native	13.9±0.58	1.00	3.5±0.28	1.00	8.4±0.31	1.00

* White population of New York State aged 20 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

both had higher rates than the corresponding groups of German-born. But the relative difference was greater among males. However, natives of German parentage had lower rates than all natives of foreign parentage. Native males of German parentage had a higher rate than native males of native parentage, but this was reversed among females. In general, the rate for natives of German parentage exceeded that for natives of native parentage, but the difference was not significant.

Because of the high rate of alcoholic psychoses in New York City, the rates were standardized further with this restriction. The standardized rate for natives of German parentage from New York City was 8.7 per 100,000, compared with 4.8 for German-born. However, the former had a lower rate than all natives of foreign parentage. They also had a lower rate than all natives of native parentage.

Thus, although second-generation Germans had a higher rate than German-born, they compared favorably with natives of

native parentage, and had a lower rate than all natives of foreign parentage.

Psychoses with Cerebral Arteriosclerosis

There were 707 first admissions with psychoses with cerebral arteriosclerosis among natives of German parentage during 1949-1951, or an average annual rate of 47.6 per 100,000.

This compares with a rate of 61.6 for German-born, and 10.5 for natives of native parentage. The differences are associated with varying proportions aged 65 years and over. Rates adjusted with respect to age are therefore shown in Table 20.

The standardized rate for natives of German parentage was 67.5 per 100,000, compared with 61.1 for German-born. They also had higher rates than natives of native parentage, but had significantly lower rates than all natives of foreign parentage.

An additional comparison will be given, based upon first admissions from New York

TABLE 19

Native-white first admissions with psychoses with cerebral arteriosclerosis, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 40	..	..	..	..	..	..	..	..	..
40-44	2	..	2	0.6	..	0.3	3.2	..	1.5
45-49	1	..	1	0.3	..	0.1	1.4	..	0.7
50-54	8	5	13	2.3	1.4	1.8	9.9	5.7	7.7
55-59	20	18	38	5.7	5.1	5.4	26.1	20.9	23.4
60-64	48	32	80	13.7	9.0	11.3	76.8	43.4	58.7
65-69	57	65	122	16.2	18.3	17.3	127.3	108.9	116.8
70-74	81	82	163	23.1	23.0	23.1	244.0	181.9	208.2
75 and over	134	154	288	38.2	43.3	40.7	359.3	257.5	296.6
Total	351	356	707	100.0	100.0	100.0	50.6	45.0	47.6

TABLE 20

Average annual standardized rates of first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of German parentage and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	74.8±5.01	1.34	54.2±3.89	1.50	67.5±3.21	1.42
All foreign-born	108.4±3.06	1.94	85.4±2.51	2.36	102.0±2.01	2.14
Native	55.7±1.86	1.00	36.2±1.41	1.00	47.6±1.18	1.00

* White population of New York State aged 45 years and over on April, 1, 1950 (intervals of 5 years) taken as standard.

City, in order to approximate the urban-rural differential.

Natives of German parentage, from New York City, had a standardized rate of 67.9, compared with 61.2 for German-born. The excess was due to a relatively high rate among native females of German parentage. However, second-generation Germans in New York City had a lower rate than all natives of foreign parentage, but their

rate remained in excess of that for natives of native parentage.

Senile Psychoses

There were 577 first admissions with senile psychoses among natives of German parentage, or an average annual rate of 38.8 per 100,000. German-born had a rate of 64.8. Natives of native parentage had the low rate of 7.0.

TABLE 21

Native-white first admissions with senile psychoses, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 50	..	..	..	..	..	..	..	..	..
50-54	1	1	2	0.5	0.3	0.3	1.2	1.1	1.2
55-59	..	1	1	..	0.3	0.2	..	1.2	0.6
60-64	3	9	12	1.5	2.4	2.1	4.8	12.2	8.8
65-69	9	27	36	4.6	7.1	6.2	20.1	45.2	34.4
70-74	41	69	110	20.9	18.1	19.1	123.5	153.0	140.5
75 and over	142	274	416	72.4	71.9	72.1	380.7	458.2	428.4
Total	196	381	577	100.0	100.0	100.0	28.2	48.1	38.8

The differences were obviously due to the disparity in age among the several populations. Rates, adjusted for age, are therefore summarized in Table 22.

The standardized rate for natives of German parentage was 45.9 per 100,000, compared with 52.4 for German-born. The difference was due to a relatively low rate among German males of the second generation. Natives of German parentage had significantly lower rates than all native whites of foreign parentage, but their rates were significantly in excess of those for natives of native parentage.

Comparisons should be limited still fur-

There is a suggestion, therefore, that the two generations of Germans had equivalent rates of first admissions with senile psychoses. The second generation had a lower rate than all natives of foreign parentage, but a higher rate than natives of native parentage.

Involutional Psychoses

There were 313 first admissions with involutional psychoses among natives of German parentage during 1949-1951, with an average annual rate of 21.1 per 100,000. German-born had a rate of 24.8. Native

TABLE 22

*Average annual standardized * rates of first admissions with senile psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of German parentage and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	30.4±3.38	1.28	51.9±3.81	1.72	45.9±2.64	1.51
All foreign-born	58.1±2.24	2.45	67.8±2.23	2.24	70.6±1.67	2.32
Native	23.7±1.21	1.00	30.2±1.29	1.00	30.4±0.94	1.00

* White population of New York State aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

ther to New York City, to compensate for differences in rates of first admissions resulting from size and density of population.

The standardized rates for New York City did not differ significantly among native-born of German parentage and German-born, the rates being 50.5 and 49.7 per 100,000, respectively. The former had lower rates than all native whites of foreign parentage, but they continued in excess of rates for native whites of native parentage.

whites of native parentage had a rate of 5.4.

Because of the effect of the age composition, the rates were adjusted, with results that are summarized in Table 24.

Native-born of German parentage had a standardized rate of 25.4 per 100,000, compared with 29.3 for German-born. The lower rate for the second generation was due to a relatively low rate among females. All natives of foreign parentage had a higher rate than natives of German parentage, but the differences are not statis-

TABLE 23

Native-white first admissions with involuntional psychoses, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 30	..	..	..	..	..	..	..	..	..
30-34	..	1	1	..	0.5	0.3	..	2.4	1.4
35-39	..	2	2	..	0.9	0.6	..	3.8	1.9
40-44	3	17	20	3.3	7.7	6.4	4.8	25.4	15.4
45-49	10	34	44	10.9	15.4	14.1	14.0	44.6	29.8
50-54	18	73	91	19.6	33.0	29.1	22.4	83.0	54.0
55-59	31	46	77	33.7	20.8	24.6	40.5	53.5	47.4
60-64	18	27	45	19.6	12.2	14.4	28.8	36.6	33.0
65-69	9	16	25	9.8	7.2	8.0	20.1	26.8	23.9
70-74	3	4	7	3.3	1.8	2.2	9.0	8.9	8.9
75 and over	..	1	1	..	0.5	0.3	..	1.7	1.0
Total	92	221	313	100.0	100.0	100.0	13.3	27.9	21.1

tically significant. However, the latter had a significantly higher rate than natives of native parentage.

Further adjustment by limiting admissions to New York City did not alter the order of differences. Natives of German parentage had a lower rate than German-born, and a lower rate than all natives of foreign parentage. But they had a higher

rate than natives of native parentage. The differences are all subject to large sampling errors.

Dementia Praecox

There were 373 first admissions with dementia praecox during 1949-1951 among natives of German parentage, or an average annual rate of 25.1 per 100,000.

TABLE 24

*Average annual standardized * rates of first admissions with involuntional psychoses to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of German parentage and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	15.8±2.04	1.46	35.6±2.83	1.60	25.4±1.75	1.56
All foreign-born	20.0±0.98	1.85	37.6±1.26	1.69	28.4±0.80	1.74
Native	10.8±0.66	1.00	22.3±0.89	1.00	16.3±0.55	1.00

* White population of New York State aged 35 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 25

Native-white first admissions with dementia praecox, parents born in Germany, to all hospitals for mental disease in New York State, 1949-1951, classified according to age

Age (years)	Number			Per cent			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Under 10	..	..	..	..	..	..	..	..	..
10-14	1	..	1	0.6	..	0.3	4.3	..	2.2
15-19	9	16	25	5.4	7.7	6.7	38.0	65.4	51.9
20-24	20	13	33	12.2	6.2	8.9	82.8	48.2	64.6
25-29	29	24	53	17.7	11.4	14.2	115.1	87.6	100.8
30-34	19	28	47	11.6	13.4	12.6	52.4	68.6	61.0
35-39	24	22	46	14.6	10.5	12.3	48.0	41.4	44.6
40-44	17	35	52	10.4	16.7	13.9	27.0	52.4	40.1
45-49	18	20	38	11.0	9.6	10.2	25.3	26.2	25.7
50-54	14	26	40	8.5	12.4	10.7	17.4	29.6	23.8
55-59	7	11	18	4.3	5.3	4.8	9.2	12.8	11.1
60-64	3	5	8	1.8	2.4	2.1	4.8	6.8	5.9
65-69	1	6	7	0.6	2.9	1.9	2.2	10.0	6.7
70-74	..	2	2	..	1.0	0.5	..	4.4	2.6
75 and over	2	1	3	1.2	0.4	0.8	5.4	1.7	3.1
Total	164	209	373	100.0	100.0	100.0	23.6	26.4	25.1

German-born had a rate of 31.8, and natives of native parentage had a rate of 24.0. These rates were influenced by the varying proportions under age 40. The rates were therefore standardized. (See Table 26.)

Natives of German parentage had a standardized rate of 42.0 per 100,000, which was significantly less than the rate for German-born, 58.2. The former also had a significantly lower rate than all

TABLE 26

*Average annual standardized * rates of first admissions with dementia praecox to all hospitals for mental disease in New York State, per 100,000 population, 1949-1951, among native-born of German parentage and selected nativity groups*

Nativity of parents	Males		Females		Total	
	Rate	Ratio to native	Rate	Ratio to native	Rate	Ratio to native
Germany	40.1±2.95	1.22	41.8±2.80	1.27	42.0±2.05	1.27
All foreign-born	52.4±1.16	1.59	49.7±1.08	1.51	52.4±0.80	1.59
Native	32.9±0.83	1.00	32.9±0.80	1.00	33.0±0.58	1.00

* White population of New York State aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

natives of foreign parentage. However, they had a higher rate than natives of native parentage.

The influence of size and density of population upon rates of first admissions is seen by limiting the comparisons to New York City. On this basis, we obtained a standardized rate of 39.6 per 100,000 natives of German parentage compared with 66.1 for German-born, an excess by the latter of 66.9 per cent. The corresponding excess for New York State was 38.5 per cent. Similarly, with respect to all natives of foreign parentage, the excess of their rate over that for natives of German parentage was increased from 24.7 for New York State to 36.4 per cent for New York City.

We noted that in the state as a whole, natives of German parentage had a higher rate than natives of native parentage. In New York City, however, there was no significant difference, the rates being 39.6 for those of German parentage, and 41.9 for those of native parentage.

SUMMARY

There were 1,777 German-born first admissions to all hospitals for mental disease in New York State during 1949-1951. Because of the high percentage at advanced age among the German-born population of New York State, psychoses with cerebral psychoses and senile psychoses predominated among them. Dementia praecox, on the contrary, included a relatively low percentage.

The average annual rate of first admissions was 218.8 per 100,000, compared with 103.9 for native whites. The former was in excess by 106 per cent. But the difference is largely spurious, because of the difference in age composition. The rates were therefore standardized, and became 169.4 for German-born and 152.0 for native

whites, an excess of only 11.4 per cent. When standardized still further with respect to New York City, the rates became 185.4 and 168.8, respectively, an excess of only 10 per cent.

The German-born had lower standardized rates than native whites with respect to disorders that may be classified as of organic origin. They had lower rates for general paresis, alcoholic psychoses, psychoses with cerebral arteriosclerosis, and senile psychoses. On the other hand, they had higher rates for involutional psychoses, manic-depressive psychoses, and dementia praecox.

The over-all rate for German-born did not differ significantly from that for all foreign-born whites. Standardized rates for New York City were 185.4 and 183.3, respectively. The rates for German-born were generally lower for the organic groups of mental disorders, but German-born had a higher rate for manic-depressive psychoses and for dementia praecox.

There were 2,541 first admissions during 1949-1951 among natives of German parentage, or an average annual rate of 171.0 per 100,000 population. Natives of native parentage had a rate of only 77.2. But, as with the foreign-born, the rate for natives of German parentage was affected by their age distribution. When standardized, the rates became 152.4 and 123.2, respectively. Thus, the excess among natives of German parentage was reduced from 215 per cent, on the basis of crude rates, to 23.7 per cent when the rates were standardized. In New York City, the rates were 145.3 and 125.9, respectively, the excess being only 15.4 per cent.

Those of German parentage had a lower standardized rate than all natives of foreign parentage, and this was reflected by each of the major groups of mental dis-

orders. As compared with natives of native parentage, those of German parentage had lower rates of general paresis and alcoholic psychoses, although the differences were not significant. There was no significant difference with respect to dementia praecox. But those of German parentage had higher rates of arteriosclerotic and senile psychoses, involutional disorders, and manic-depressive psychoses.

Rates of first admissions among natives of German parentage and natives of native parentage are not entirely comparable because the former constituted a second generation, whereas the latter included third and older generations in unknown propor-

tions. More direct comparisons cannot be made since the census does not give the necessary data with all required detail.

A final comparison may be made between natives of German parentage and German-born. In general, the former had a lower rate. Thus, the over-all standardized rates for New York City were 145.3 and 185.4, respectively, the latter being in excess by 28 per cent. The second generation had lower rates with respect to involutional psychoses, manic-depressive psychoses, and dementia praecox. They had higher rates for alcoholic psychoses and psychoses with cerebral arteriosclerosis.

A SPECIAL EDITORIAL BY
SHELDON GLUECK

Remarks in honor of William Healy, M.D.

EDITOR'S NOTE: *Professor Glueck presented the following address on May 22, 1963, at a memorial program honoring William Healy, M.D. The program was held at the Judge Baker Guidance Center, Boston, Mass. Other speakers included Frank W. Crocker, George E. Gardner, M.D., director of the Center, Marion E. Kenworthy, M.D., George S. Stevenson, M.D., and the Hon. G. Howland Shaw.*

Dr. Healy died in Clearwater, Fla., on March 15, 1963, at the age of 94. An internationally recognized pioneer in the field of juvenile delinquency, he was the director of the Judge Baker Guidance Center from 1917 to 1949. He was also a founder and first president of the American Orthopsychiatric Association.

I trust I may be pardoned for reminiscing,

Professor Glueck is Roscoe Pound Professor of Law, Emeritus, Harvard Law School, Cambridge, Mass.

in rather personal terms, about my contacts with Dr. Healy and what his friendship has meant to me. His wide-ranging intelligence and his unfailing kindness had a considerable influence on me.

When Mrs. Glueck and I first came to Boston in 1922, one of the first people I called on was Dr. Healy, whom my brother, Dr. Bernard Glueck, greatly admired. Dr. Healy introduced me to his co-worker Dr. Augusta Bronner, and I felt honored to meet and speak to them both in their famous laboratory. I told Dr. Healy I was interested in criminology and that I had been particularly impressed with his book *The Individual Delinquent*. I still regard this work as a classic in pioneering thought on the wellsprings of human motivation and conduct. Although it was published in 1915, it would benefit many present-day criminologists and clinicians to study that volume.

Dr. Healy was interested in the fact that I was attempting, in my doctoral thesis, to combine criminal and constitutional law with psychiatry and psychopathology. I submitted my dissertation to the publisher, Little Brown, with faint hope that they would publish it. Thus, you can imagine how thrilled I was to receive a telegram, in the summer of 1925, notifying me that Dr. Healy had read the manuscript for the publishers, had thought highly of it, and had recommended its publication. That work, under the title *Mental Disorder and the Criminal Law*, was to have a profound influence on my future, for it led to my appointment as assistant professor at the Harvard Law School where I have remained ever since. So I am deeply grateful for the generosity and encouragement shown by the pioneer whose memory we are honoring today.

But that was only one of numerous kindnesses shown by Dr. Healy—and to many other young people, I am certain. In a remarkable seminar conducted by Dr. Richard C. Cabot in the Department of Social Ethics at Harvard, the outstanding practitioners in all branches of social work in Boston participated; the most outstanding of all were Doctors Healy and Bronner. The object of the seminar was to evaluate the various techniques employed by the different agencies engaged in helping troubled people who were caught up in what Dr. E. E. Southard had aptly called, "the kingdom of evils."

I well remember the wise and trenchant presentation made by Doctors Healy and Bronner. Most impressive was their scientific attitude; I thought at the time that here were another Pierre and Marie Curie. They did not oversell their approach to the clinical study of delinquency. They let the techniques speak for themselves, in contrast to the exclusively legal or senti-

mental attitudes toward delinquency. They also pointed out that the so-called behavioral disciplines were still in a very rudimentary state, but that this did not mean that they should not be employed, with caution, to the extent that they were relevant to the understanding of human motivation and social pressures.

At that seminar I made the point that nobody had really checked up on the human products of our reformatories and prisons; that if any other enterprise were run in so slipshod a way, it would soon go bankrupt. Both Dr. Cabot and Dr. Healy responded enthusiastically to the idea of making a follow-up study of the graduates of the Massachusetts Reformatory. Indeed, back in 1915, in his great work, *The Individual Delinquent*, Dr. Healy had said:

"A very weak point in practically all social and moral therapy is the lack of follow-up work. Criticism may be extended to parents who have no patience to deal systematically with a problem child, to court admonitions which imply the ability of human nature to change itself in a trice, to public administration which sends back old offenders from institutions to an environment where they are almost sure to fail again" (p. 178).

That seminar, and the encouragement given there to two young researchers, led to the follow-up study, *500 Criminal Careers*, which Mrs. Glueck and I published in 1930, and subsequently, to the researches published under the title, *One Thousand Juvenile Delinquents, 500 Delinquent Women* and, indeed, to a whole train of investigations which have occupied us through several decades, and which we plan to expand and deepen during the coming years.

You can see, therefore, that Dr. Healy was, in a sense, a major catalyst of our work.

Now Dr. Healy believed that under-

standing could come largely through study of the *individual*. He knew that before you could fruitfully speak of thousands of cases, you had to examine a single case thoroughly. In recent times, however, there has been an unwarranted and, in my view, an uninformed slur on the clinical, individual-person and family approach to the study and treatment of predelinquents and delinquents. Everything now is claimed to be "subcultural" group, class and mass. It almost seems as if the individual and the family count for nothing; and that in comparison with all-pervasive social forces, there is virtually no such thing as genes or early parent-child relationships. All is supposedly cultural, communal, societal.

A multifaceted research, involving the techniques of physical anthropology, medicine, psychiatry, psychology, Rorschach testing and the study of home and school life¹ is scornfully dismissed by certain "social scientists" as "merely eclectic" and as yielding nothing but a "hodge-podge" unguided by a theory.²

Nowadays it is a familiar exercise to attribute human maladjustment, and particularly delinquency, to one, all-embracing influence which certain criminologists raise to the dignity of a "theory." But this does not conceal the *unilateral causal* approach which they did so much to discredit when Lombroso described the "born criminal" type. Neither Dr. Healy nor his life-time collaborator, Dr. Bronner, have ever been so learnedly naive as to

believe that there is but one source or set of influences in human maladjustment.

Perhaps the greatest contribution of the man to whose work and worth we today pay tribute is his effective insistence on the multiplicity of influences, both genetic and environmental, in the etiology, therapy and prevention of delinquency.

And there are several crucial statistics that cast doubt upon the almost propagandistic ardor with which certain social scientists keep harping on the overwhelming if not exclusive etiologic influence of group, class and subculture culture in delinquent conduct. Let me state briefly the basis of this doubt.

As to *gang-membership*, for example, it was established in the book *Unraveling Juvenile Delinquency*, which Mrs. Glueck and I published back in 1950, that almost nine-tenths of the 500 persistently delinquent youths compared in that work with 500 true nondelinquents, had already shown clear signs of antisocial behavior when they were less than 11 years old, while sociologic studies have demonstrated that the typical "gang age" is well beyond that period—in adolescence. Besides, about half of our delinquents never did join gangs, although they live in underprivileged urban areas where there were such more or less organized groups; but they were indubitably delinquent, whether by the test of the law, or of the clinician.

As to *neighborhood-subculture*, even in the most marked "delinquency areas" of our cities not more than a small proportion of the boys (perhaps 10 or 15 per cent) become delinquent.

As to the *wider, general, anti-social culture*, the New York City Youth Board found that in America's leading urban center no fewer than 75 per cent of the delinquents are contributed by only 1 per cent of the families.

¹ See, Glueck, Sheldon and Eleanor Glueck, *Unraveling Juvenile Delinquency* (New York: The Commonwealth Fund, 1950).

² This work has been reprinted numerous times, and has twice been translated into Japanese. A popular version, *Delinquents in the Making*, (New York: Harper & Bros., 1952), has been translated into French, Italian, German and Urdu.

If the gang influence and the neighborhood and the culture and the class status are as generally and permeatively involved in the etiology of delinquency as some criminologists claim, how can one account for such facts and figures?

If you will examine *The Individual Delinquent* and the works published by Doctors Healy and Bronner, including their stimulating series of case history studies, you will see that these trail-blazing clinicians did not limit their vision to any single fact, theory or explanation. They also knew the difference between causes and effects.

In 1915 Dr. Healy pointed out that:

"The well-directed procedure first establishes the relation between cause and effect; it does not proceed from a possible cause to a perceptible fact, which may really be due to another cause. The knowledge that 60 per cent of all repeaters come from bad homes does not prove that any particular repeater comes from a bad home, nor does it prove that the bad home in any given case produced the delinquency. There should be evaluation of the personal traits of a bad young man from a bad home, as well as a bad young man from a good home, if effective reconstructive measures are to be undertaken. Treatment of environment, as many a wise probation officer clearly perceives, turns out to be another highly individualized problem" (p. 285).

The truth is that it is not any single social or organic influence that accounts for delinquency. As is true of disease, it is differential *contamination* that is involved; and contamination implicates not merely *exposure* to delinquency patterns, cultures or companionships, but also the immunity or nonimmunity of the particular individuals so exposed.

It would be good for some modern criminologists to go back to the wise insights of Healy's *Individual Delinquent* and not devote their total effort to neighborhood, class and subculture. Admittedly, the mas-

sive pouring of millions of dollars into slum areas will, at least for a term of years, provide new opportunity, improve housing and the physical conditions under which the underprivileged in urban areas now live. But it will not purchase mother love, or fair and firm paternal discipline of the children, or warm and supportive family cohesiveness. If those criminologists who are fascinated by sweeping concepts of neighborhood, class, group, and delinquency subculture would bear the insights of Healy in mind, they might then understand Oscar Wilde's cynical, yet all too often truthful observation, in *The Picture of Dorian Gray*, that "Children begin by loving their parents; as they grow older they judge them; sometimes they forgive them." They might also see the relevancy of Edmond Rostand's famous rooster Chanticleer, who was convinced that it was his crowing at dawn that caused the sun to rise.

That Dr. Healy understood clearly the *selective* influence of environmental pressures is obvious in all his writings. As a further illustration, here is another passage from *The Individual Delinquent*:

"We should always like logically to separate physical from psychical environment. Occasionally this can be successfully done, but frequently the two conditions thoroughly overlap. As we look over a long list of environmental conditions which we have found as causes, it stands out that most of the defects can be classified properly only under the head of conditions which have directly had mental influence on the offender" (p. 285).

It should be borne in mind that Dr. Healy did his pioneering clinical work in Chicago at a time before psychiatry had become thoroughly animated by the vital ideas of dynamism and energy in mental process, and before such Freudian conceptions as infantile sexuality and the

devious influence of subconscious forces had become common knowledge among clinicians.

Nevertheless, one sees in the passage just quoted a natural recognition that environmental influences do not always lie outside the individual; that, indeed, they have little influence on the individual until, through selective introjection, they have been transformed from external phenomena common to the mass and class of persons into pushful motives of separate individuals.

That Dr. Healy kept abreast of developments in the then heatedly attacked pronouncements from Vienna is clear when one recalls that *The Individual Delinquent*, published, in 1915 and written during the course of earlier years, contains a fair and perceptive section on psychoanalysis (pp. 115 *et seq.*) Indeed, he reminds the reader that "early mental experiences and strange, altogether hidden, mental conflicts have arranged the destinies of many a chronic offender" (p. 120).

At the same time, Healy did not minimize the external environmental pressures which may invade the home and overwhelm parental barriers and thus transform an otherwise beneficent under-the-roof culture into a malign milieu. However, to emphasize through repetition, let me remind you that he stressed his conviction that "The story of the effect of bad environment in producing delinquency is only to be told by giving an account of the psychical effects of the unfortunate conditions. Poverty and crowded housing, and so on, by themselves," he insisted, "are not productive of criminalism. It is only when these conditions in turn produce suggestions and bad habits of mind and mental imagery of low order that the trouble in conduct ensues" (p. 284).

He went on to illustrate that "a public

playground is no incentive toward good conduct unless better mental activities and better mental content are fostered there. In illustration we might tell of incidents which have occurred when just such a meeting place was afforded boys and girls, one they otherwise would not have had, and where many ideas of delinquency were concocted and spread. All problems connected with bad environment," he concluded, "should be carefully viewed in the light of mental life" (p. 284).

But to remind us all of the noble spirit and creative mind of the man whose character and contributions we are attempting to evaluate today, let me lay before you some of the extracts quoted by Dr. Healy in the frontispiece to his distinguished book:

"Give therefore thy servant an understanding heart—to judge thy people."—Solomon's Prayer, I Kings, iii:9.

"Socrates. 'And yet, O my friend, if true opinion in law courts and knowledge are the same, the perfect judge could not have judged rightly without knowledge!'" —Plato, *Theaetetus*.

"There is only one principle in penology that is worth any consideration: it is to find out why a man does wrong and make it not worth his while." Devon, *The Criminal and the Community*.

One more observation by Dr. Healy, by way of conclusion:

"Offenders can never be treated properly," he insisted, "unless their problems are understood. No machinery of court or institution, however well-organized, can ever take the place of deep humanistic understanding. The girl put it well who blurted out to a certain judge, 'You and your officers are here to do your duty, and I suppose you are going to send me away, but before I go I want to tell you one thing; you don't at all understand me' (p. 179).

Dr. Healy was one of those rare souls who really understood.

Book Reviews

CRADLES OF EMINENCE

By Victor Goertzel and Mildred G. Goertzel

Boston, Little, Brown & Co., 1962, 362 pp.

This book is a survey of 413 individuals of eminence. The study was conducted by two research psychologists who have long been interested in the background of famous and talented people.

The authors' method of selection for inclusion in this study was as follows: "Include each person born in the United States who has at least two books about him and all persons born outside the United States who have at least one book about them. Include in the biography section of the Montclair, N. J., Public Library, only those who lived into the twentieth century and are described in a standard reference work."

As a result, 413 individuals of as widely different backgrounds as the artist, Amedeo Modigliani, and the labor leader, David Dubinsky, were included. The authors attempted to extract from these biographies common denominators in the childhood experiences of these individuals in an attempt to understand their ultimate eminence. Chapter headings such as "Opinionative Parents," "Troubled Homes," "Children Who Had Handicaps," etc., result.

The reviewer found this particular method of study both interesting and frustrating. Reviewing the backgrounds of these individuals resulted in some cogent observations, such as, "Recent fashion in parental attitude favors the neutral parent who is warmly supportive, provident, non-directive. . . . The neutral parental attitude was practically unknown to the families in this study. . . . The children in these opinionative homes are more likely to emu-

late the parent than to be rebels." There are, of course, many similar observations that were suggestive and pointed.

Conclusions were often derived from what seemed to be meager data and were quite impressionistic. It is also thought that the method of selection left something to be desired, inasmuch as the choice of eminence as a selection factor results in a very heterogeneous group. It is felt that a greater refinement of choice would have made for a more valuable and interesting study. In fact, it is hoped that the authors will provide a more detailed study, with a greater precision of observation, at some future time. In any event, the survey is both interesting and provocative.—ROBERT COUNTS, M.D., Children's Psychiatric Center, Inc., Eatontown, N. J.

PSYCHOLOGICAL INTERPRETATION

By Leon H. Levy

New York, Holt, Rinehart & Winston, Inc., 1963, 368 pp.

The author considers psychological interpretation as an activity which consists of presenting an alternate frame of reference or redefining a given set of observations or behavior in order to make manipulation possible. Any interpretation consists of two aspects: the semantic, which deals with ways of describing the event, and the prepositional, which is concerned with relationships between events.

Levy sets out to develop a single set of principles which are to be utilized in all interpretation, regardless of the material to be interpreted. He discusses, at length, interpretation in psychodiagnosis, tests and psychotherapy. Since interpretation

changes behavior, the theory must explain how this is effected.

It is assumed that the individual's behavior is guided by what he is trying to accomplish—or his plan—and by his image—or inner representation of the world. Involved also is sensitivity to the act so that if it is not in harmony with the plans and images, it is modified before it becomes overt. Interpretation, by making possible changes in plans and images, facilitates changes in behavior. For interpretation to be effective many guideposts need to be observed. The stimulus for change is dissonance or discomfort, ranging from mild tension to extreme anxiety.

Levy presents a theory of interpretation in the form of axioms and postulates. Listed as axioms are the statements that plans, images and interpretations control behavior; alternate interpretations are possible; dissonance is aversive and is never totally reduced; individuals differ in their tolerance for dissonance and that interpretation produces dissonance.

Among the postulates and corollaries presented are: the need for patient and therapist to share a common language; that the patient will choose the interpretation which will reduce dissonance, otherwise it will be distorted or rejected; acceptance of an interpretation is influenced by the status of the therapist; the greater the dissonance the greater the change in the patient's plans and images; the greater the dissonance produced by an interpretation, the greater the possibility that the therapist will acquire aversive qualities, etc.

In therapy it is essential to prepare the ground for interpretation, and many factors are involved, such as the relationship, dissonance, timing, frequency, as well as the personality of the clinician.

The author makes a serious effort to discuss an important clinical area. The style

is frequently ponderous in spite of the attempt to simplify the presentation of the theory of psychological interpretation by couching it in mathematical language of axioms and postulates. We still have a long road to travel.—SIMON H. TULCHIN, New York, N. Y.

READINGS IN ADOPTION

Edited by I. Evelyn Smith

New York, Philosophical Library, Inc., 1963, 532 pp.

The social service function in adoption is the primary focus of this compilation of articles. Miss Smith, who is professionally well-qualified for the test she undertakes, recognizes that her readers may disagree with her selections. She tries to present various points of view, and she does succeed in providing a much-needed perspective on today's adoption practices.

This is a balanced presentation; there is a wide geographical representation of social workers and agencies, and the time-span is from the 1940's to the present. The author points out that there are some areas of adoption practice where writings are practically nonexistent.

The book is logically organized into sections, including general concepts and basic philosophy of adoption, and services to natural parents, to the child, and to adoptive families. The author presents a clear and helpful introductory statement about the subject matter in each section. Although there is some duplication of content in the articles, this is kept to a minimum. This is not a book one would normally read from cover-to-cover, and the reader can easily select articles of individual interest.

The section on the contribution of other professions to the field of adoption is particularly important. Also, the need for

continuing research in all areas of adoption is emphasized. The author's look into the future poses many challenging problems.

Miss Smith provides a source book of great value to the individual practitioner, trained or untrained, and a useful tool for inservice training programs. Since most of the articles are relatively free from "social work journalese," they are also of interest to other professionals and to the lay reader.—MRS. RUTH LATIMER, M.S., Social Welfare Research, Inc., Cincinnati, Ohio.

THE CHALLENGE OF THE RETARDED CHILD

By Sister Mary Theodore, O.S.F.

Milwaukee, The Bruce Publishing Co., 1963, 204 pp.

One of the outstanding books for parents of retarded children has recently been reprinted in a second edition, with minor changes. Since its first appearance, *The Challenge of the Retarded Child* has offered an excellent survey for troubled parents and an inspiring starting point for teachers contemplating specialization in work with the mentally handicapped.

Based on thirty years of work with exceptional children, the volume affords an encyclopedic coverage of the many forms of retardation and an encouraging account of the daily happenings at St. Coletta's School, an institution for the mentally handicapped. The style is simple and narrative, suited both in language and in content to the needs of parents.

Encouragement is the keynote of this book; it stems from the religious point of view and from emphasis on the idea that "you are not alone." Doctors, scientists, educators, government agencies, private foundations, and parents' organizations are

striving, through different approaches, to ameliorate the widespread problem of mental retardation.

The principal changes in this second edition are an extension of the bibliography, a brief discussion of programmed instruction for marginal retardates, a short summary of the work of the President's Panel on Mental Retardation, and the inclusion of a well-written foreword by Eunice K. Shriver, executive vice-president of the Joseph P. Kennedy Jr. Foundation. Mrs. Shriver stresses the desirability of volunteer assistance to the retarded by those who have leisure and by those who are preparing to be ministers, doctors, and teachers.—RUTH ANNE KOREY, Ph.D., Fordham University School of Education, New York, N. Y.

ELECTRICAL AND DRUG TREATMENTS IN PSYCHIATRY

By A. Spencer Paterson

New York, American Elsevier Publishing Co., Inc., 1963, 248 pp.

After reading *Electrical and Drug Treatments in Psychiatry*, this reviewer was immediately impressed by the extensive experience of the author, whose presentation reveals a well-organized approach to the physical treatment of mental disease.

Valuable references to the literature, in addition to an accompanying detachable drug data chart, add to the practical usefulness of the volume. The importance of ECT is re-emphasized, and the various techniques of electrical treatments are well-described in a practical manner.

The field of physical treatment in psychiatry now encompasses a vast area of knowledge. However, Dr. Paterson thoroughly covers the entire area for the

clinician. He has been able to present the essential material in 248 pages. It is hoped that he will find time in the future to add new material to this first edition as the field of neuropsychopharmacology advances. This book is strongly recommended for residents in psychiatry, practicing psychiatrists, internists, general practitioners, and medical school faculty members as an aid in keeping abreast with the rapid advances in this field.—DONALD M. GALLANT, M.D., Department of Psychiatry, Tulane University School of Medicine, New Orleans, La.

PREVENTIVE PEDIATRICS; CHILD HEALTH AND DEVELOPMENT

By Paul A. Harper

New York, Appleton-Century-Crofts, Inc., 1962, 798 pp.

The author, formerly a practicing pediatrician, wisely saw the need for a book describing the predictable patterns of healthy and troublesome development in children. He knew that pediatrics textbooks had traditionally covered specific illnesses, but gave little attention to the whole child, his supervision, training, or education.

There is excellent coverage of almost every developmental period and most of the common problems encountered by parents and pediatricians in their ordinary care of children. There is an appropriate, extensive bibliography, and explanations are offered in a reasonable clinical manner for almost all the causal factors pediatricians might ordinarily look for and consider. Important subjects like the menarche and menstrual problems, phobias and fears, feeding patterns, mental retardation, sensory defects and specific learning disorders are well-described.

There is little reference, however, to the psychodynamic influences on all of these problems. It is evident that the author has magnificent orientation in pediatrics and public health, also in children's institutions and schools, but there is disappointingly minimal reference to psychoanalytic contributions.

It is true that the explanations and advice offered are sensible, such as that an infant will thrive best with a "good" mother regardless of the mode of feeding, ("breast or hand"), but modern pediatricians are ready for more than just a word about the unconscious elements involved. Now and then the author or his colleagues approach closely and then stop before penetrating deeply. Rumination, for example, is described as "pleasurable chewing of the cud," and that it can be treated by "playing with the child and drawing him away from himself." Mention of the need for psychiatric "advice" is made for "great tensions [in] severe and persistent refusal of food which results in malnutrition."

Public and school health services are covered with full, up-to-date, accurate statistics. Methods of preventing and dealing with such conditions as epilepsy, cardiac and sensory defects and such common problems in social medicine as the unwed mother and illegitimacy are well-described. Recurring attention is given to methods of discipline, although one may discover ambiguity in the differentiation between permissive discipline and obvious indulgence. Thus, the author obliquely condemns psychoanalytic contributions as follows (page 711): "The philosophy of promises, or of equating wants with needs, which has been encouraged by the Freudian school and other forces in our society, has influenced widespread breaking of the moral codes."

Perhaps this book might have included a chapter on the normal integration of the family patterned after the basic contributions of such men as Gerald Pierson and Fred Allen. The family drama which opens with the birth of the first infant should be well-understood by every practicing pediatrician. It is noted that no John Hopkins' child psychiatrist was included on the board of contributors, most of whom are members of the Hopkins' faculty.—OSCAR B. MARKEY, M.D., Cleveland, Ohio.

PSYCHOTHERAPY IN THE SOVIET UNION

Translated and edited by Ralph B. Winn

New York, Grove Press, Inc., 1962, 207 pp.

This book presents a translated selection of about one-half of the 57 papers published in the original proceedings of a conference on psychotherapy held in Moscow in 1956. The papers are quite brief and sketchy, and for the most part comprise reports or commentaries on the psychotherapeutic interests or activities of the participants.

In their total impact they reveal that psychotherapy is a new emerging interest of Soviet psychiatrists, that there is a growing realization in the USSR that personality, psychodynamics and psychotherapy are important not only in the neuroses but in the psychoses and in general medicine as well, and that their theoretical frame of reference is a rather fragile structure of common sense, reliance on suggestion and hypnosis, group pressure, environmental manipulation, rational exhortation and Pavlovian doctrine.

It would be easy to deal slightly with these simple unsophisticated claims and

formulations and to compare them unfavorably with the glib and theoretically ornate or experimentally well-controlled productions of our own psychiatric culture. One should not, however, overlook the importance of the trend these Russian papers represent, or to underestimate its potential for growth and development. As with some of the simple realistic contemporary Soviet paintings, it is sometimes refreshing to enjoy their candor and directness. Soviet psychotherapy confronts us again with some old and simple verities: many mental disturbances are often due in whole or part to the vicissitudes of experience, and different personalities react differently to particular experiences.

The essays convey in one way or another the message that the physician must understand both the patient's personality and his experience and help the patient to understand himself too. To gain these insights the physician must relate well to the patient, and to drive home his lessons he must use the full power of both reason and suggestion, with or without hypnosis. Group therapy can often help. The basic function of psychotherapy is re-education. Some of the claims of psychotherapeutic success seem to be extravagant: a case of baldness cured in 12 sessions, and similar claims of cure of drug sensitivity, toxemia of pregnancy, epilepsy, psoriasis, lactation difficulties, etc. But as ardent proponents of a new approach their zeal is understandable.

The translation is not always correct. In Russian usage psychotherapy may be called "verbal therapy," but this should not be translated as "speech therapy," which is quite different.

Seven years is a long time in contemporary Soviet science and better, fuller formulations of psychotherapy (such as Myasishchev's *Personality and Neuroses*)

can already be found in the Russian literature. But what is really lacking to date is a single comprehensive Russian volume that combines a well-documented formulation of the psychology of personality and of the neuroses with a discussion of pertinent psychotherapeutic techniques. The elements for such a project are at hand, and it will not be long before that task will be undertaken.—JOSEPH WORTIS, M.D., Jewish Hospital of Brooklyn, Brooklyn, N. Y.

THE SOCIOLOGICAL REVIEW
MONOGRAPH NO. 6: THE
CANFORD FAMILIES;
A STUDY OF SOCIAL CASEWORK
AND GROUP WORK

Edited by Paul Halmos

*Keele, Staffordshire, England, University of Keele,
1963, 240 pp.*

The Canford Families is a report of a social work "experiment" in an urban area in England, a neighborhood with a tradition of "social disturbance." Sixteen families which had not yet reached any social agency, but which were considered to have problems because of the behavior or adjustment of a child member, were selected for the study.

Acknowledging the importance of and concern with prevention, the study states as a primary aim "to see how families threatened with a breakdown could be helped early, . . . releasing social work from the straitjacket of isolated responses to acute crises which are uneconomical of time and energy, and often ineffectual because underlying problems remained unacknowledged." It tested an additional hypothesis; that children in trouble reflect basic family problems.

The approach was a joint casework-

group work attack, using additional resources where they were required. Reading the report calls to mind the recent social work literature in the United States dealing with "multiple problem," "hard-core families," "aggressive casework," and the increasing impetus toward family-focused service. It reflects the most recent theoretical and practical work that has been the concern here in the past decade. This is amply documented in the rationale for the project and the bibliographical references.

The chapters of the report, written by the several project staff workers, deal with the backgrounds and problems of the families, details of the actual process with four of them, the organization and methods of the project unit, the group work with the children, the use of psychiatric consultation and casework with the families as family therapy.

The project was set up as a special but temporary family service unit, separate from other community family service or child guidance agencies. The experimental aspect afforded the staff an opportunity for a leisurely and flexible operation not always possible in a more structured setup with its usual pressures and larger case loads. The project is not research in the sophisticated sense. It lacks precise definitions of categories (as in "organized" and "disorganized" families), and of measurements of movement, change, success, etc.

However, the results and conclusions support the validity of the general theme and the specific hypothesis, both in impressionistic and empirical terms. The work with the families was not treatment in the clinical sense, but the value of the "total" approach on any level is supported by the outcome of the project.

Emphasizing the importance of the degree of emotional investment the family

is able to make and the importance of working with the whole family (usually in the home, not in an office), the report concludes that the concept of ". . . family identity . . . is of value in assessment of families and their adequacy for meeting the needs of their members. Where family identity is clearly defined and contains strong positive elements, the family can provide the individual with support and allow room for growth and variety . . . [it] focuses attention on a family's strengths—its security and flexibility, and its capacity for co-operative functioning."—NATHAN W. ACKERMAN, M.D., The Family Institute, Inc., New York, N. Y.

MARRIAGE

By Robert O. Blood, Jr.

New York, The Free Press of Glencoe, Inc., Division of Crowell-Collier Publishing Co., 1962, 515 pp.

Robert Blood's textbook is an extensive exposition of an extensive and basic aspect of living, deceptively simplified in the one-word title *Marriage*.

The approach correctly concerns itself with marriage as a phenomenon of the life-cycle extending over a period of many years, during which time it has several aspects, several stages, requires several kinds of adjustments and behaviors of its participants.

The book is introduced by a section on the meaning of marriage. There the emphasis is on marriage as a personal relationship—as opposed to other kinds of relationships—and requiring particular skills in order to fulfill particular functions, both personal and social. This comprehensive but summary discussion sets the tone for the ensuing sections on Courtship, Marriage and Family Living.

Courtship is broadly conceived as the

entire process leading to marriage. The chapters in this section analyze dating, choosing a marital partner, mixed marriages, the development of love and its personal and physical expression, readiness for marriage, engagement, and the wedding and honeymoon as rites of passage.

The section on marriage deals with marital roles and their maintenance, divorce and remarriage, decision-making, division of labor, finances, relatives, religion, leisure and sex.

In the final section on family living there are chapters on family planning and the advent of children and on parental roles in socialization and education of children.

The many and detailed chapters approach the material in the context of the most recent knowledge from the several social sciences, and include tabulations of pertinent statistical data from sociological and psychological studies. Throughout, there is an orientation to the personal and emotional components of behavior, its consequences and its relationship to the social environment. Values, shared goals, gratification of emotional needs, creative growth and development of individuals, as individuals and as members of a family, underlie the discussion of each of the many chapters and their subheadings. This is epitomized in the statement "Personal relations are ends in themselves, not means to ends."

It is this context which gives meaning to the wealth of facts presented across such a broad spectrum of topics. The style of writing and presentation of data are simple and do not require a sophisticated social science background on the part of the reader. Thus, the book has value and usefulness as a basic text for the college student.—NATHAN W. ACKERMAN, M.D., The Family Institute, Inc., New York, N. Y.

THEORIES OF THE MIND

Edited by Jordan Scher

New York, The Free Press of Glencoe, Inc., Division of Crowell-Collier Publishing Co., 1962, 748 pp.

One does not have to proceed very far in this volume to become aware of the tremendous work and organization invested by Dr. Jordan Scher, the editor. He has assembled an outstanding group of authorities in the fields of psychiatry, psychology, philosophy, theology, and physiology—some 35 individuals—and, to presents their views. There is a wealth of information, theory, and discussion of theory. One can open this book at almost any given place and find subject matter of interest.

Theories of the Mind is divided into three sections. The first concerns basic considerations of physiology, biochemistry and behavior. Topics include such areas as "Explorations in the Psychophysiology of Affect" (Charles Shagass), "Material Aspects of Mental Disease" (R. W. Gerard) and "The Biology of the 'Prejudiced' Mind" (H. Liddell).

The second section is philosophically oriented. There are 13 essays; 4 of these are authored by physicians. Mind is viewed, discussed and defined from a number of interesting viewpoints. The editor joins this section with a challenging presentation of "Mind as Participation." It is difficult to read this section without finding one's own thoughts stimulated, as, obviously, have been those of the contributors.

The third section deals with mind as method, and includes a group of articles on such subjects as introspection, memory and hypnosis.

Dr. Scher's volume is excellent. Most of it reads well and is authoritative. There are the inevitable special strengths and

weaknesses implicit to the multiple-author exposition. The editor, however, has done a fine job of bringing together many diverse viewpoints and backgrounds. He is to be commended for his endeavors and the production of a book which merits a place in every major library of the humanities.—HENRY P. LAUGHLIN, M.D., Mount Airy, Md.

POPULAR CONCEPTIONS OF MENTAL HEALTH

By Jum C. Nunnally, Jr.

New York, Holt, Rinehart & Winston, Inc., 1961, 311 pp.

Popular Conceptions of Mental Health is the report of a six-year research project carried on by the Institute of Communications Research at the University of Illinois under a grant from the National Institute of Mental Health.

The major areas of investigation were, first, the measurement and analysis of information and attitudes of the public and a group of experts in the field of mental health, and of the content of mental health material in the mass media; and second, methods of effecting change in the knowledge and attitudes of the general public.

The various studies that make up the report include detailed descriptions of the methodology and design of each investigation. The appendix contains the several measuring instruments used in the collection of the data. Both the text and the appendix are replete with tabulated material and statistical analyses. For the reader who may find some of this beyond him, each chapter concludes with a simple and lucid summary.

In the analysis of information questionnaires and opinion polls taken from a public sample the study shows that the public

level of information is not "bad" (they are uninformed rather than misinformed) but that attitudes are "bad" (that is negative) toward mental illness and the mentally ill. It is interesting to note the finding that correctness of information correlates with variables such as age and education, while attitudes do not. Old and young, highly educated and uneducated, tend to have negative attitudes toward mental illness.

Data analysis from a sample of experts (psychiatrists and psychologists) queried on public information programs showed general agreement. When disagreement was subjected to factor analysis, it was found that the difference was not *between* the psychiatrists and the psychologists, but *within* both groups and centered on the best methods of psychotherapy and the causes of mental disorder.

Study of the mass media content reveals that their ideas of mental health are less "correct" when compared to expert opinion than the beliefs of the general public. The period covered in this study is 1954-1959. It would be interesting to rerun some of the studies in the light of the many television network dramas on mental illness that have been popular in the last two or three years. One can speculate about the possible changes in public opinions and mass media content and about their direction.

Findings on comparisons of public attitudes toward psychiatry and general medicine; and on attitudes of the general practitioner toward mental illness and the mentally ill (which are as "bad" as those of the public) present significant and important problems for community education programs. Questions around referrals, use of services and prevention are all influenced by such attitudes and the practices that ensue.

Further findings relative to emotional effects of mass media material and the changes in information and attitudes after controlled experimental education programs make this volume a valuable handbook for anyone working in the field of mental health education. It not only offers specific suggestions for effectively presenting material and changing negative attitudes to positive ones, but also raises important questions for further consideration and study.—MOTTRAM TORRE, M.D., New York, N. Y.

PSYCHOTHERAPY AND SOCIETY

By W. G. Eliasberg

New York, Philosophical Library, Inc., 1959, 200 pp.

The author speaks as physician, psychologist, court psychiatrist, humanitarian. He refers to his own early interest in small group research, industrial psychiatry and social forces. Almost any argument is bolstered by references in German and French, but is always firmly rooted in our own ways and literature.

In Dr. Eliasberg's early professional years, he experienced the psychoanalytic movement from within and from without. The differences among the schools of psychiatry were keeping them apart. He was convinced that they must agree on a common denominator. Therefore, he helped to organize an international meeting in psychotherapy in 1926, since psychotherapy needed to be brought back into "clinical medicine after an absence of 100 years."

Dr. Eliasberg believes strongly in psychoanalysis as the only treatment for psychoneurosis. But he takes pains to say that neither psychoanalysis nor existentialism has solved all of the problems of human existence, any more than great phi-

losophers solved it previously. He has doubts as to the persistence of the present *a deux* method, and sees much greater scope for group techniques.

He says it should be permissible for a psychotherapist to charge a poorer patient less without being analyzed by his colleagues, and, too, it should be allowed that the therapist give one patient more time than another as the need (of the patient) arises. He displays masterful understanding of how to use variations in psychotherapeutic methods—when to stop before shattering the personality by loosening compulsive or hysterical defenses in certain socially integrated personalities.

Schizophrenia, says Dr. Eliasberg, seldom is really treatable by psychotherapy, "yet we must not give up efforts to understand other human beings, even though psychotic." There is no rejection on his part of any medical technique which can help a particular patient. Hypnotism is sanctioned only when the therapist has sufficient training coupled with caution. He states clearly: you cannot treat a psychopath by any method.

An unorthodox view on the legal and therapeutic aspects of traumatic neurosis is worth quoting:

"The expert who makes the scientific; i.e., always hypothetical, assumption of a causal relationship in an accident neurosis may want to offer his opinions as to (a) the degree of incapacitation, (b) the methods and probable results of treatment, (c) prognosis of effects on the organism, his morbidity and life expectancy, (d) effect on permanent incapacitation within the vocation, (e) indirect effects, inasmuch as the person is responsive not only to the bodily harm but also to the changes in capacity and actual performance. In doing so, he will keep in mind that there are cases where the neurosis is not 'forgotten' after settlement, and, on the other hand, cases which yield to modern analytic and group treatment even after 20 years. Some experts will, in their conscience, weight the effect of high award which

may do harm to the claimant by uprooting his will to work and his will to live."

"Should the expert predict good result from treatment, with reasonable probability the defendant will find it in his interest to guarantee the cost; the jury will, in such a case, be guided in its stipulation and will make the cost of treatment a part of the award. No doubt, a number of claimants want to be treated because their mental and physical health is worth more to them than a large payment."

Two readings were required for me to comprehend adequately the general theme of this small, very compact book. The frequent interposition of small type and the encyclopedic scope are more distracting than would be a simple theme in bolder type. After perusal of the 200 pages, the reader is convinced that Dr. Eliasberg is very erudite and would know what to do in any given case. The contents of the book do not transmit these attributes to the reader, although they add to his store of information.—ESTHER SOMERFELD, M.D., and EUGENE ZISKIND, M.D., Los Angeles, Calif.

SUICIDE AND SCANDINAVIA

By Herbert Hendin

New York, Grune & Stratton, 1964, 153 pp.

Suicide and Scandinavia presents the results of an intensive investigation of suicide in Sweden, Denmark, and Norway, "offering meaning for the "Scandinavian suicide phenomenon;" i.e., the proportionally high suicide rates in the first two countries and the low rate in the last.

Decisive influences contributing to suicide in these different cultures are shown to be related to differences in handling dependency needs and aggression, family discipline, relationships between the sexes,

attitudes toward success and performance, and attitudes toward death, life-after-death, and suicide itself. Of significance is the finding that suicide rates in Denmark and Sweden are high for reasons that are quite different.

Solely as a contribution to the understanding of the motivations underlying suicide, the book can be highly recommended. In addition, however, the volume demonstrates the applicability of psychoanalytic interview techniques to the study of cross-cultural problems and "psychosocial character," illustrating the usefulness of fantasy, free-association, and dream material when so utilized.

Dr. Hendin found corroborating support for inferences from such data in the national folk tales, popular literature, and cartoons of the culture, as well as in the results from psychological tests. The reviewer is especially intrigued by Dr. Hendin's use of dreams occurring during the period of the suicide attempt and, in their absence, by the interviewer's suggestion to the hypnotized patient that he will have a dream similar to the one he might have had before his suicide attempt.

Dr. Hendin demonstrates other aspects of interviewing technique which can be usefully applied to other patients, suicidal or not. He points out, for example, how interviewers frequently neglect to ask about such relevant data as attitudes about death, life after death, and suicide.

The total presentation is to be commended. Dr. Hendin makes his points in a concise and interesting manner. He includes valuable illustrative case material, which, fortunately, is not overly extended in elaboration. For the value of its contribution, it would not be surprising to find *Suicide and Scandinavia* considered one of the outstanding books in the field of mental hygiene for the year 1964.—ARTHUR C.

CARR, New York State Psychiatric Institute, New York, N. Y.

SCHIZOPRENIA AS A HUMAN PROCESS: THE EARLY WORK AT SHEPPARD-PRATT

By Harry Stack Sullivan

New York, W. W. Norton & Co., Inc., 1962, 363 pp.

It is always a pleasure for the psychiatrist to come across explanatory antecedents in patients or in book form. Harry Stack Sullivan's early papers on schizophrenia prove a double reward; the presentation of the clinical data leading to his formulated theories and the biographical and bibliographical foundations of his views.

Helen Swick Perry has again proved a discerning editor. She has presented in brief commentaries the circumstances of publication, and she has included abstracts of other papers which are not in this volume. The papers cover the period from 1923 to 1930 when Sullivan was at the Sheppard and Enoch Pratt Hospital, first as assistant physician, later as director of research.

In the clinical descriptions and discussions, Sullivan shows his skill in bringing order into the fragmentary histories and the interview records. He documents his initial observations on onset and prognosis, always in the context of a dynamic understanding of the patient. One can see his growing conviction of the importance of puberty and adolescence as crucial factors in the susceptibility to schizophrenic disorder. It is stimulating to see the confluence of Freud's psychopathology, Meyer's psychobiology, and the followers of George Mead's social psychology shaping Sullivan's own emerging genetic theory of development.

The papers dealing with Sullivan's inter-

est in the social sciences are of particular relevance today when many collaborative research efforts have increased our knowledge of the institutional subculture. For clarity of presentation, Sullivan's discussion of the treatment of schizophrenia is noteworthy. However, I cannot agree that his style is Joycean, as the editor suggests. Instead, it seems evident that Sullivan was not a prose stylist at heart, and many ele-

gant thoughts are buried in grammatical obscurity.

Discussions are included with several papers. These lively interchanges document the exciting and controversial developments occurring in American psychiatry at that time and attest to Sullivan's early generative influence on the psychiatry of schizophrenia.—DEXTER M. BULLARD, JR., M.D., Boston, Mass.

Notes and Comments

RECORD BUDGET PROPOSED FOR NATIONAL INSTITUTE OF MENTAL HEALTH

The National Association for Mental Health is recommending that Congress appropriate a record \$208,917,000 for the National Institute of Mental Health for fiscal 1965. This is \$25 million over the amount appropriated by Congress for the Institute for fiscal 1964, and \$20 million over the total budget proposed by President Lyndon B. Johnson.

The NAMH is recommending increases over the President's proposed budget in the following items: the hospital improvement program; Mental Health Project grants; clinical research centers; regular training grants; inservice training; and the General Practitioner Training Program.

For the over-all 1965 NIMH budget the NAMH recommends \$87,495,000 for research; the President is requesting \$76.4 million. For fellowships the NAMH and the Administration are proposing \$8,057,000. For training the NAMH recommends \$82,213,000; the President is requesting \$73.2 million. For state control programs the NAMH and the President are proposing \$6,750,000; and for direct operations the NAMH and the Administration recommend \$24,402,000.

TAX INSTRUCTIONS INCLUDE MENTAL ILLNESS ON DEDUCTIONS LISTING

For the first time this year U. S. taxpayers using the tax instructions issued by the Internal Revenue Service saw mental illness and mental retardation on the list of diseases and disabilities for which contributions are deductible. This change came about as a direct result of action taken by the National Association for Mental Health in 1963.

TRAINING

A unique educational project designed to produce graduate social workers trained for service to the emotionally disturbed, mentally retarded child got underway in the Bronx, N. Y., in October, 1963.

A special student unit from Adelphi University Graduate School of Social Work is now located at the Jewish Child Care Association's Edenwald School.

The Edenwald School, which has pioneered in service to educable retarded children whose emotional disturbance necessitates their placement away from their families, serves 64 boys and girls, aged 8 to 16. The residential treatment program embraces specialized and remedial teaching techniques, a therapeutic group living environment and a complete range of professional services. Although the six members of the Adelphi training unit are equally divided between casework and group work students, the Edenwald experiment is featuring cross-specialization, with casework trainees given one or more groups in addition to their caseloads, and group work trainees required to carry one or two cases plus their group assignments.

After the results of the first year have evaluated, consideration will be given to expanding this student training project on an agency-wide basis, beginning at the point of application for placement and continuing on for a period after the child's discharge from agency care.

* * *

Again this year the Western Interstate Commission for Higher Education and the Western Council on Mental Health Training and Research are sponsoring a Summer Work-Study Program in Mental Health.

Any undergraduate or graduate student in any field of study in a Western college or university who wants to explore career

possibilities in mental health may apply to one of the six participating colleges.

The 10-week program includes two weeks of intensive academic work and eight weeks in on-the-job assignments at one of a number of facilities for the mentally ill or mentally retarded.

CARE AND TREATMENT

The trial visit and foster home program of the Veterans Administration Center in San Juan, Puerto Rico, is considered a successful operation, according to a report prepared by Wilson Gonzalez, clinical social worker at the Center.

Mr. Gonzalez states that the program was slow in the beginning but now operates successfully "because of the general attitude of the Puerto Rican families in accepting the patients, regardless of their condition."

The establishment in 1960 of a 10-bed ward for neuropsychiatric patients at the VA Center provided the impetus for the trial visit program. In September, 1961, the first door was opened to a mental patient. Since that time 19 patients have been placed in foster homes. VA staff hold monthly meetings with the foster mothers to orient them in handling the patients and to discuss problems.

Mr. Gonzalez' report states that despite some community resistance, the program has become firmly established. He singles out the area of Trujillo Alto where there is a lower middle-income neighborhood and co-operation among neighbors is "the law of the land." Here, he states, the patients have been incorporated into the community to such an extent that they form an important part of the group and are included in all community activities.

* * *

Striking results of a new program to return

mental patients to their homes within a few months were announced recently by the National Institute of Mental Health.

Two-thirds of the seriously ill patients in the program have been successfully restored to a useful place in society, according to scientists at the Psychiatric Research Center, Saint Elizabeths Hospital, Washington, D. C.

A 44-page brochure titled "A Comprehensive Psychiatric Center," by Dr. Fritz A. Freyhan, director of clinical studies at the Center, and Dr. Julia A. Mayo, chief of clinical social service, which describes the new program, has been published by the Government Printing Office. It will be mailed, on request, to psychiatrists and other mental health professionals.

The Center, set up two years ago on the grounds of Saint Elizabeths Hospital by the NIMH, practices some of the new ideas in psychiatric care which were included in the newly enacted community mental health center legislation.

The Center's two key features are a broad range of services—within reasonable distance from the patient's home—including a hospital, a day hospital, a clinic and home service; and a flexible system of moving the patient from one type of treatment to another, depending upon his progress.

In addition, from the first day of the patient's admission, his family is helped to prepare for his return home. The Center explains the patient's condition to the family and offers information and reassurance. The Center also keeps in touch with the patient and his family after his return home to provide periodic checkups and to help prevent relapses.

REPORTS, STUDIES, SURVEYS

Patients who are residents of state and county mental hospitals in the United

States decreased in number during 1963 for the eighth consecutive year, according to a Public Health Service report.

The 1963 total of 504,947 public mental hospital patients represents a decrease of 9.7 per cent of the hospital resident population—or 53,975 fewer individual patients—since 1956, the first year in which the total number of resident patients in public mental hospitals declined. In the year 1962–1963, the decrease was 2.1 per cent.

The shrinkage of state and county mental hospital resident population has been achieved during the eight-year period even though the number of persons admitted to mental hospitals has increased, according to data assembled by the Biometrics Branch of the National Institute of Mental Health.

The rise in admissions to these hospitals, which began in the mid-1940's, continued during 1962–1963, for a jump from 267,068 admissions in 1962 to a total of 285,244 in 1963, or a 6.8 per cent increase.

According to the Public Health Service report, net releases from mental hospitals have almost doubled in the years between 1955 and 1963, from a 1955 total of 126,498 net releases to a new total of 247,228 net releases last year.

During the same eight-year period, the report continues, the average per diem expenditure per patient in state and county mental hospitals has increased \$2.75—from \$3.06 in 1955 to \$5.81 in 1963.

* * *

Mental illness need not be a barrier to successful employment, a recent Veterans Administration study indicates. The VA reports that of a sample of 2,049 veterans of World War II and the Korean conflict who had service-connected psychiatric disabilities, 1,421 were employed. Approximately 290,000 have such disabilities.

Of the employed veterans, 15 per cent were diagnosed psychotic, 85 per cent psychoneurotic. About 3 in 10 were rated as seriously disabled (30 per cent or more disability). Their employment was distributed over the entire range of occupational groups, from unskilled to executive. About 16 per cent were self-employed.

The survey found that the psychiatrically disabled showed a high degree of job stability. Three-fifths of the employed group has been with their employers five years or more; only 11 per cent less than one year.

* * *

CONFERENCES AND MEETINGS

Two nine-day work conferences, covering identical content and focusing on "Vocational Rehabilitation of the Mentally Retarded in a Residential Treatment Setting" will be conducted during the summer of 1964 by Teachers College, Columbia University, and the Devereux Schools. The conferences will be held at the Devereux Schools from June 22 to June 30, and repeated July 13 to July 21.

The conference content will stress the residential setting as a rehabilitation resource for evaluation, counseling, training and placement of the mentally retarded. A limited number of Vocational Rehabilitation Administration traineeships are available to meet the cost of travel and maintenance. Professional workers engaged in the rehabilitation of the mentally retarded, general rehabilitation workers, graduate students, workshop administrators and professional workers in related areas are invited to apply. Further information and application blanks may be obtained from the work-conference coordinators: Professor Abraham Jacobs, Box 106, Teachers College, New York, N. Y. 10027; or Dr. Henry Platt, Devereux Schools, Devon, Pa.

The 1964 workshop on Education in Human Relations and Mental Health will be held at the State University of Iowa, Iowa City, June 15-26. The purpose of this workshop, now in its fifteenth year, is to provide an opportunity for school personnel, public health nurses, community group leaders and others to become acquainted with recent developments in the behavioral sciences and mental health. Inquiries on the workshop should be addressed to the co-ordinator, Ralph H. Ojemann, Ph.D., Institute of Child Behavior and Development, State University of Iowa, Iowa City.

* * *

The 120th Annual Meeting of the American Psychiatric Association will be held at the Biltmore Hotel in Los Angeles, May 4-8, 1964. Tentative plans call for major addresses by Governors Edmund G. Brown and Nelson A. Rockefeller and labor leader Walter Reuther. A session on co-ordinated action for mental health has been set aside as the "John Fitzgerald Kennedy Memorial Session."

* * *

The Academy of Psychoanalysis will hold its annual meeting at the Los Angeles Biltmore on May 2 and 3, just prior to the APA conference. The theme of the two-day meeting is "The Creative Process," with sessions on "A Study of Creativity in Westinghouse Science Scholarship Winners," "Creative Process in the Arts," and "Application of Psychoanalytic Concepts to the Study of Literature."

* * *

The First International Congress of Psychodrama, focusing on all methods of training in human relations, will be held in Paris, France, August 31-September 3, 1964. Delegates from 48 nations are expected to attend. Inquiries should be ad-

ressed to J. L. Moreno, M.D., P. O. Box 311, Beacon, N. Y.

APPOINTMENTS AND ELECTIONS

Paul H. Pearson, M.D., has been appointed head of the newly organized Mental Retardation Branch of the Public Health Service. The branch was established as a means for improving and extending the availability of health services to the mentally retarded. It will provide financial assistance to the states for the planning of comprehensive services for the retarded.

Dr. Pearson has been a postdoctoral fellow in mental retardation at the University of California at Los Angeles. He also has had several years of specialized private practice with children suffering from neurological disorders and handicaps.

* * *

In recognition of the growing importance of social worker research in the Veterans Administration Department of Medicine and Surgery, the Department has appointed a chief of social work research.

He is Lewis W. Carr, D.S.W., research social worker at the Houston, Tex., VA Hospital since July, 1961, who will have the primary responsibility for the formulation, development and administration of the social work research program in the Veterans Administration.

AWARDS AND GRANTS

The National Association for Retarded Children has announced the establishment of the Gunnar Dybwad Distinguished Scholar Award in the Behavioral or Social Sciences. The award is in the form of a sustaining grant in the amount of \$25,000 annually for a period of five years, and subject to renewal.

The award is a commitment to a suitable research institution in support of the work

of a behavioral or social scientist of distinction whose research efforts have been, or will be, devoted in large measure to studies in mental retardation.

The award honors Dr. Gunnar Dybwad who for the past seven years served as director of the NARC. Individuals do not apply for the award; instead, a candidate must be nominated by his department chairman, the dean of his college or other administrative officer. Letters of nomination should be sent to Abner Wolf, M.D., chairman, Research Advisory Board, National Association for Retarded Children, 386 Park Avenue South, New York, N. Y. 10016, before June 15, 1964. It is planned to announce the award at the NARC annual convention in October.

HONORS

Miss Emily L. Martin, who retired January 1, 1964, after 48 years of service to the National Association for Mental Health and its parent organization, the National Committee for Mental Hygiene, was honored at a party held in her honor at the NAMH National Office in December, 1963. Since 1952 she has been responsible for the Association's Information and Reference Service.

Philip E. Ryan, executive director, extended the appreciation of the NAMH for Miss Martin's many years of service. George S. Stevenson, M.D., editor of *Mental Hygiene* and former medical director of the National Committee for Mental Hygiene, outlined Miss Martin's career and her many contributions to the citizens' mental health movement.

She was also honored at a recent meeting of the Association's Executive Committee. In behalf of the National Board, NAMH president Frank E. Proctor presented her with a book of letters of ap-

preciation from her associates throughout the early years of her service and those from more recent years.

Over the past 48 years Miss Martin's interests and efforts have touched every phase of activity and development in the mental health field: legislation, psychiatric services in general hospitals, psychiatric education, mental hospital surveys, professional fellowship and other training and personnel placement, statistics, education and information. She has also had a special interest in the National Health Library, established in 1921, and over the years she has helped develop its mental health and psychiatric reference sections.

She served under the four medical directors of the National Committee for Mental Hygiene: Thomas W. Salmon, M.D., who held the post from 1912-1922; Frankwood E. Williams, M.D., 1922-1931; Clarence M. Hincks, M.D., 1931-1939; and George S. Stevenson, M.D., 1939-1950.

Miss Martin joined the staff of the National Committee in February, 1916, to work with Clifford Beers, founder of the mental hygiene movement, and with Dr. Salmon.

In 1917 the National Committee devoted the major part of its efforts to the formation of psychiatric units in the armed forces. Miss Martin worked closely with Dr. Salmon and Dr. Williams on this project. The published history of this program became a valuable aid to those engaged in similar work during World War II.

Of her association with Dr. Williams, Miss Martin says, "he taught me what I know about mental health." In addition to his duties as associate medical director, and later as medical director, he was the first editor of *Mental Hygiene*, a post he held for 15 years.

During 1929 and 1930 Dr. Williams was in charge of arrangements for the First In-

ternational Congress on Mental Hygiene and chairman of the Committee on Program, and Miss Martin played an important role in assisting him with the administration of the Congress. It was held in Washington, D. C., in May, 1930, and attracted an attendance of 3,500 persons from 53 countries.

Emily Martin also served as chief administrative aide to the National Committee's Division of Psychiatric Education, created in 1931. She worked on an intensive study of medical school training programs, which was directed by Franklin G. Ebaugh, M.D., and also assisted Dr. Ebaugh and Adolf Meyer, M.D., with the planning of four conferences on psychiatric education.

Also in the 1930's, Miss Martin worked closely with Samuel W. Hamilton, M.D., director of the Mental Hospital Survey Committee, which included representatives of eight leading medical and lay organizations.

In addition to her many contributions to the National Committee and, later to the NAMH, Miss Martin has devoted herself to scores of "extra" projects and publications, which have had the benefits of her extensive knowledge, wide experience and unique facility for providing, instantly, significant facts, statistics and historical data about mental health, mental hospitals and related subject matter.

In the past two years she has assisted with the preparation of two significant publications in the mental health field: *Mental Health in the United States: A Fifty Year History* by Nina Ridenour, Ph.D., and *Pioneers in Mental Health* by Robin McKown.

In concluding his tribute to Miss Martin, Dr. Stevenson quoted these lines from Oliver Goldsmith's "The Deserted Village."

"While words of learned length and
thundering sound

Amazed the gazing rustics ranging
around

And still they gazed

And still the wonder grew

That one small head could carry all he
knew."

* * *

The University of Toronto conferred an honorary degree of doctor of laws on Clarence Meredith Hincks, M.D., on November 22, 1963.

Dr. Hinks was the founder and general director of the Canadian National Committee for Mental Hygiene (now the Canadian Mental Health Association) from 1918 to 1952. He was executive director of the U. S. National Committee for Mental Hygiene from 1931 to 1939

He was cited by the University of Toronto as a benefactor of Canadian and world society. The citation also stated that "every patient in every mental hospital in Canada, every person who pops a pill in his mouth to combat mental illness, every troubled mind who finds a friendly welcome at a White Cross Center, indeed every Canadian owes a debt of gratitude to Dr. Clare Hincks."

Just before the degree ceremony, Dr. Hincks was the guest of honor at a Dinner of Tribute held at the Faculty Club of the University. He was presented with a Book of Acclaim, filled with over 200 messages and tributes. Included were messages from the Prime Minister of Canada and members of his cabinet, the White House, and many other leading Americans and citizens of the United Kingdom.

ARTICLES SCHEDULED FOR PUBLICATION IN FUTURE ISSUES OF MENTAL HYGIENE

"Resistance to Psychological Care of Hospitalized
Children: Observations on Socioprofessional Fac-

- tors in the Resistance Process" by Arthur Stein.
- "A Tale of Moses: Post-Doctoral Interlude" by Arthur L. Rautman.
- "Symbiosis of Hospital and Community: Opinions of Residents, Employees and Volunteer Workers" by Charles V. Lair and Allen W. Byrnes.
- "Psychiatry Re-enters the Community" by C. H. Hardin Branch.
- "The Personal and Family Strength Research Projects: Some Implications for the Therapist" by Herbert A. Otto.
- "The Mental Health Professional in the Community: Some Generalizations for Effectiveness" by Allen Hodges.
- "Bilingualism: A Brief Review" by Kaoru Yamamoto.
- "Foster Homes for the Mentally Ill" by Helen Padula.
- "Developing Consultation Relationships with Community Agents" by Fortune V. Mannino.
- "The Common Grounds Between Psychiatry and Religion" by Hector J. Ritey.
- "Adjustment and Mental Health Attitudes in Foreign Students" by Arthur Nikelly, Mineyasu Sugita and Jack Otis.
- "A Study of the Membership and Program of a Club for Expatriates of Mental Hospitals" by Mabel B. Palmer and E. Lee Hoffman.
- "An Analysis of Attitudes of Professional Personnel Regarding Mental Retardation as a Field" by Melville Appell, Clarence M. Williams and Kenneth Fishell.
- "Shifting Patterns of Affection: Transitional Figures" by R. V. Heckel.
- "The California Recovery House; A Sanctuary for Alcoholics" by Robert Martinson.
- "Preventing Mental Ill Health in Early Childhood" by Ivor Kraft.
- "The Concept of a Community Mental Health Clinic: Fact or Fiction?" by Michael J. Pacella.
- "Contributions of a Speech Pathologist to the Psychiatric Examination of Children" by Clyde L. Rousey and Povl W. Toussieng.
- "A History of Challenges in Child Psychiatry Training" by I. N. Berlin.
- "Alcoholics Anonymous Principles and the Treatment of Emotional Illness" by Felix Cohen.
- "Therapeutic Approaches in a Psychiatric Day Treatment Center" by Julian Meltzoff and A. A. Richman.
- "An Oblique Approach to Clients with Behavior Disorders" by Robert B. Miller.
- "Reactions of Children During Hospital Admission: Three Diaries" by Joseph Mayer.
- "Functions of the State Mental Hospital as a Social Institution" by Robert M. Edwards.
- "Natural Family Pointers to Foster Care Outcome" by H. B. M. Murphy.
- "Pragmatic Psychiatry and Traveling Community Mental Health Clinics" by Lindbergh S. Sata.
- "A Perspective on the Function of the Psychiatric Halfway House" by Geoffrey A. Sharp.
- "Psychiatric Role of Physical Medicine and Rehabilitation in the Third Revolution" by John Eisele Davis, Sr. and John Eisele Davis, Jr.
- "Basic Issues and Problems in Attendant Training" by M. K. Distefano, Jr. and Margaret W. Pryer.
- "An Evaluation of the Effectiveness of a Mental Hygiene Video Presentation on Adjustment" by Robert M. Blume, Sheldon Blackman and Jonah P. Hymes.
- "A Note on Tolor's 'The Personality Need Structure of Psychiatric Attendants,'" by M. Powell Lawton.
- "Is There Inner Strength for Mental Troubles?" by Ordway Tead.
- "The Public Image of the Sex Offender" by Gerhard J. Falk.
- "Discovering and Meeting the Mental Health Needs of Emotionally Disturbed Elementary School Children, with Emphasis on Children Whose Parents Are Inadequate" by Sol Gordon, Morris Berkowitz and Charles Cacace.
- "Family Organization on a Modern State Hospital Ward" by H. Peter Laqueur and Harry A. LaBurt.
- "Two Remarkable Achievements of Social Therapy: The French Psychiatric Hospitals of Saint-Alban and Lannemezan" by Paul Rajotte and Hermann C. B. Denber.
- "Attitudes and Opinions of Clergymen about Mental Health and the Causes of Mental Illness" by Richard F. Larson.
- "Implications of Process-Reactive Schizophrenia for Rehabilitation" by R. E. Kantor.
- "Effect of Physician Training in Mental Health Principles on Mothers' Appraisal of Child Health Conference" by Marvin Belkins, Edward S. Suchman, Daniel Rosenblatt and Harold Jacobziner.
- "The Stigma of Mental Illness Can Be Erased" by Sister Loretta Maria.
- "A Study of the Use of Mental Health Media by the Lay Public" by Alexander C. Rosen and Frank F. Tallman.
- "The Integration of Community Psychiatry Training in a Traditional Psychiatric Residency" by Robert S. Daniels and Philip M. Margolis.
- "Specialization and Under-Utilization" by Mortimer Schiffer.

"The Impact of Psychiatric Hospital Experience on the Community Adjustment of Patients" by David G. Berger, Charles E. Rice, Lee G. Sewall and Paul V. Lemkau.

"Constructive Use of Psychiatric Consultation in a Rehabilitation Program" by Meyer S. Gunther, Clement Blakeslee and Ralph W. Susman.

"The Role of the Psychiatrist in the Peace Corps" by Philip M. Margolis.

"Mental Health Factors in an Indian Boarding School" by Thaddeus P. Krush and John Bjork.

"Metastasis: A Social Psychological Concept Concerning Mental Health and Illness" by Martin Bloom.

"Interviewing Techniques for Social Work Student Training" by G. Alpine, R. Chester, N. Kaufman, J. Matsumuro and M. Cunningham.

"The Social Psychology of Prejudice" by Nathan W. Ackerman.

"A Study of Children's Attitudes Toward the Cuban Crisis" by Bernice T. Eiduson.

"A Skeptic's View of the Mental Illness Game" or "An Old State Hospital Hand's Jaundiced Look at Progress" by Walter B. Simon.

"Personality Correlates of the Orientation of Mental Hospital Attendants" by Neil F. Thomas, Robert L. Houk and Herbert S. Ripley.

"Studies of Medical Student Attitudes Toward Mental Illness" by Leonard F. Salzman and Robert H. Goldstein.

"Expanding Comprehensiveness of Psychiatric Rehabilitation" by Laurence C. Hartlage.

"Pupil Perception of Parental Attitudes Toward School" by Margaret Barron Luazki and Richard Schmuck.

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Notes and Comments

Psychiatry re-enters the community

Psychiatry was originally very much a part of the community. Aberrant behavior could usually be tolerated easily in rural or semirural communities, and only when it disturbed others was it taken under active consideration.

Then it became a sociotheological matter, and the disturbed person was, according to the time and place, treated with cruelty or custodial and protective care, usually under the control of a church or some other religious organization. This applied, of course, only to those individuals whose families could not care for them. As early as the fourth century B.C., Plato¹ said,

"If a man is mad he shall not be at large in the city, but his relations shall keep him at home any way which they can; or if not, let them pay a penalty. . . . Now there are many sorts of madness, some arising out of disease . . . and there are other kinds which originate in an evil and passionate temperament and are increased by bad education; out of a slight quarrel this class of madmen will often raise a storm of abuse against one another, and nothing of that sort ought to be allowed in a well-ordered state."

There may be some question as to whether Plato is considering only people who would nowadays be classified as mentally ill or whether he is including those who would today be regarded as demagogues or fanatics. Whatever the situation, he is very clear on the state's responsibility: to take care of the matter, working through the family if possible.

Through the centuries, the mentally ill, when they received any care at all, received it at the hands of the religious organization, and often there was a smooth progression from the religious asylum to the hospital asylum. One such case appears in the

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¹ Dialogues of Plato, *Laws*, Book XI (Chicago: University of Chicago, 1952). Great Books edition, Vol. 7, p. 782.

famous Bethlem Hospital, first established in 1247 as a priory, then converted into an institution for the care of the insane when six patients were admitted in 1403. The present hospital is functioning under the same name in a pleasant rural setting outside London; has an active patient government and a community-oriented treatment program.

An equally famous institution which developed in a somewhat different direction is the Colony Gheel and its Central Hospital. In the twelfth century the Shrine of St. Dymphna (beheaded by her "possessed" father and therefore the patron saint of "possessed" persons) had so many visitors that living space was provided for them in the surrounding village. Through the years, the Central Hospital was developed and built, but the custom of housing most of the patients with local families continued, bolstered by tradition and religious precedent. Two years ago there were some 2,000 patients in the colony, with about 300 in the Central Hospital itself.

Similar colonies have existed at Lierneux, Belgium; at Clairmont, France, under the direction of the Brothers Libatte; in Hanover and in Moravia, and these, too, have apparently operated successfully.

In our own country, the first hospital established specifically for the care of the mentally ill was built under circumstances which again demonstrate the transition from a community responsibility for the mentally ill to a hospital-centered treatment program. In Williamsburg, Va.,

according to the "Official Guidebook of Colonial Williamsburg."²

"In Colonial times the care of the insane, *like the care of paupers* [italics mine], was considered a local matter and usually was left to the vestry of the parish. The vestry was unable to finance or maintain an asylum, and hence the insane were either left at large in a world with which they could not cope or placed in prison where they were often badly mistreated. The humane Governor Francis Fauquier . . . directed the attention of the burgesses to the need for better care for 'persons who are so unhappy as to be deprived of their reason' and an act was passed in 1770 'to make provisions for the support and maintenance of ideots, lunatics, and other persons of unsound minds.'"

The building was completed in 1773 and for many years was known as the "Lunatick Hospital;" more recently it became the Eastern State Hospital. Incidentally, it may be of interest to note that the original building cost was 1070 pounds!

We note, then, a shift from community responsibility, particularly in the smaller social units of counties, towns, or even families, to institutional responsibility for the care of the mentally ill. These institutions had the form and often the administrative framework of hospitals, although inadequate budgets, disinterest on the part of the public and their political representatives and general fear of "maniacs" often allowed them to provide no more than custodial, often prison-like, care. The inevitable result was isolation: political, professional and geographic.

Sometimes the geographic isolation was deliberately sought in order to obtain more space, better and fresher air and more recreational facilities for the patient. The Pennsylvania Hospital in Philadelphia had been established in 1752 and contained cells for mentally ill patients. Conditions were far from adequate. Bond³ describes the situation as follows:

² *Official Guidebook of Colonial Williamsburg* (Williamsburg: Colonial Williamsburg, Inc., 1960), pp. 70, 102.

³ Bond, Earl D., *Dr. Kirkbride and His Mental Hospital* (Philadelphia: J. B. Lippincott Co., 1947), 26-27.

"... a main trouble was overcrowding, which was to dog and retard every step for the improvement of mental hospitals for the next hundred years. Men and women in all sorts and conditions of mental disease were placed too closely together on a basement floor. The buildings occupied less than three-quarters of an acre, even including the 'Airing Ground.' Patients whose illness had begun only a few weeks before their admission were placed with those who had been in the hospital from 25 to 42 years. The overcrowding led to too much restraint, idleness and the deprivation of niceties. It led to mischief, noise and protests from the medical and surgical patients, just above them. A physician worrying about his surgical patients wanted more and more restraint below and lost his concern for the mental patients. . . . In 1833 an experiment was made of heating six of the lunatic cells by flues and pipes, but most of the cells went unheated. The visitors who poured into the central city hospital showed a morbid curiosity and pertinacity in attempting to see and stir up 'the mad people.'"

As a result of these unhappy conditions, plans were made to build special facilities for the mentally ill patients at some distance from the center of town and this was accomplished in 1841. Perhaps similar situations caused the New York Hospital to establish Bloomingdale Asylum some seven miles out of New York, and the Massachusetts General Hospital to build McLean Hospital four miles out of Boston.

One end result was, obviously, improvement in the physical comfort of the patients, but a secondary result was the geographic isolation of the psychiatric hospital from the main stream of hospital practice. This isolation has remained troublesome ever since.

Not all isolation was due to a desire to get space and fresh air for the patients, for in many instances the public hospital was placed where land was cheap or in a part of the state which justified some political patronage, or in an area where farming could be carried on as part of the hos-

pital activities. These are all justifiable reasons for the placement of hospitals, but they do not help when one tries to argue that mentally ill patients should be handled just like other sick people, when one tries to help the patient maintain close contact with his family and friends, or when one tries to set up day hospitals, night hospitals or follow-up care programs.

Under these circumstances it was understandable that hospital personnel, feeling themselves exiled with their patients, turned their attention to such matters as the efficiency of their dairy herds and settled for running a trouble-free custodial institution. After all, hospital superintendents, at least in comparatively recent times, received no thanks for a rising discharge rate, but they stood to lose a great deal if a single discharged patient made a nuisance of himself or damaged some person or property.

This was how matters stood for a great many years. Patients were "treated" humanely [the word is in quotes because the humane care did not actually constitute treatment in a dynamic sense], fairly successful attempts were made to raise the per capita per diem cost of operating the hospitals, staffing patterns were improved, and the number of hospital patients became steadily greater.

It was obvious that hospitalization alone did not provide the answers—not that there were any therapeutic measures available which seemed to offer much for the great mass of mentally ill patients—and psychiatry seemed to be divided between the activities surrounding public hospitals and the one-to-one psychotherapy which characterized much of private practice. The latter was somewhat higher on the status totem pole and there was far too little contact between the two groups.

Then came the dramatic increase in interest in psychopharmacology, beginning in

the early 1950's. Discussion of the various drugs is not germane to this paper, but what is significant is the fact that the use of the drugs, the confidence that something positive could be done for the patient, and perhaps a magical belief in the efficacy of chemotherapy combined to produce an increased discharge rate from the hospitals. Strangely enough, the discharge rate in some instances was increased even in groups of patients who were not receiving drugs, and it was suggested that perhaps the attitudes of the patients, their psychiatrists and their families had changed to permit earlier trial visits and earlier discharge even if recurrences of the illness and readmissions did somewhat cloud the picture.

This, with other findings, brought sharply into focus the fact that a considerable number of patients could not maintain themselves outside the hospital because their families or the community would not accept them or because they could not regain their previous occupation. Especially was this true of the older patients, and a return to the hospital often remained the only possible course of action for them.

There were available community resources which could help with this problem: mental hygiene clinics, marriage counselors, vocational rehabilitation programs, adult education classes, foster homes, community centers, etc., etc. But unfortunately, the contact between these facilities and the hospitals was not close and, in many instances, was actively discouraged by both sides. The reasons for this justify some discussion.

Psychiatry has been criticized for its isolation. Gorman⁴ quoted the late Dr. Alan Gregg's speech at the Centenary Meeting of the American Psychiatric Association in Philadelphia in 1944 as follows:

"We would all agree that psychiatry is the most isolated of the specialties in medicine. . . . As a natural consequence of their isolation, psychiatrists speak a dialect, a special lingo more productive of resentment than comprehension or interest on the part of their medical brethren, and so defeat the very object of language, which is communication of ideas. Another consequence of isolation, provincialism, with all its clannish distrust of outsiders and its equally petty loyalties, appears too often as the signature of your specialty in the estimation of other medical men."

It is worth noting that 50 years before, S. Weir Mitchell, M.D., LL.D.,⁵ said,

"You were the first of the specialists and you have never come back into line. It is easy to see how this came about. You soon began to live apart and you still do so. Your hospitals are not our hospitals; your ways are not our ways."

Both these gentlemen were referring to the isolation of psychiatry from the rest of medicine, but Dr. Gregg was also referring to cultism and isolation within psychiatry itself, and Dr. Mitchell was speaking specifically about the hospital side of psychiatry. Both these problems continue to plague us. There are few public hospitals with broad community relationships, and even now the Veterans Administration forbids its full-time physicians to engage in remunerative work in the community, even when there is real community need and when the activity would not interfere with full-time work in the Veterans Administration.

On the matter of the isolation of the hospital psychiatrist from the community psychiatrist, many training programs contribute to the difficulties by divorcing hospital work from outpatient work, often assigning

⁴ Gorman, Mike, *Every Other Bed* (New York: World Publishing Co., 1956), 49-50.

⁵ Mitchell, S. Weir, "Address before the 50th Annual Meeting of the American Medico-Psychological Association," in *Transaction of the American Medico-Psychological Association*, 1(1894), 101-121.

the more junior residents to the inpatient unit and reserving outpatient clinics for the more senior trainees. While the American Board of Psychiatry and Neurology has been making steady progress in encouraging training programs to provide more and broader hospital experience for their residents, there are still situations in which the emphasis on outpatient work is so great that public hospital experience is almost nonexistent.

Perhaps part of the trouble, at least on the part of the hospitals, is administrative. In 35 states the administration of the state hospitals and the mental health authority are vested in the same bureau or commission. Even in these states there is considerable possibility that the state mental health program and the state hospital program are carried in different divisions, and in those states where the two are separated at a higher level, communication must be difficult indeed.

When the state hospital superintendent has been accustomed to battling for more funds against other state agencies, he is not likely to view with ecstasy the growth of a community mental hygiene program in another part of the state political system, competing with him for funds and designed for handling outpatients—the most favored of psychiatric patients. In this situation, the superintendent may develop an outpatient program of his own, ignoring the fact that when the hospital is isolated from much of the state, an outpatient clinic at the hospital can serve only the community in which the hospital is located.

Hospital-administered outpatient clinics scattered throughout a state which also has a community program inevitably means the duplication of clinical facilities—deplorable in the face of shortages of personnel—conflicting loyalties and doubling of administrative costs. Ridiculous as this may seem,

I know of one southern state which, until very recently, had precisely this situation, with clinics sometimes occupying adjacent offices, and I know of another state in the intermountain area where the hospital superintendent is planning an outpatient clinic to serve the area around the hospital, ignoring the fact that there is already a community clinic in operation.

I am aware of the fact that in many places these difficulties are handled by direct communication between the various individuals involved, but I am afraid that these are the exception rather than the rule. And even if the superintendent and the director of the community program can communicate comfortably and easily, each may have difficulty enlisting the support of his other staff members. Beckerman, *et al.*,⁶ comment:

"To realize the rehabilitation potential of the community center, we have had to overcome resistances from our psychiatric staff. They were reluctant to refer patients to center programs, and even more reluctant to assume psychiatric leadership of integrated activities at the center. When the patients were off the floor, the nurses felt deserted—a fact noted and commented upon by patients and supervisors alike! Psychiatric residents, preoccupied with 'formal' therapy, tended to regard social rehabilitation with disdain. The relationship between nursing, occupational therapy and social group work activities had to be closely scrutinized. The more usual practice of referring patients to a social recreational facility only after hospital discharge was critically reviewed by the social work staff."

It seems to be a fact that integration of the hospital with the community is a difficult task, requiring tremendous diplomacy, a real will to communicate and to integrate, and a sincere conviction on the part of both parties that a combined program is the only

⁶ Beckerman, Aaron, Seymour Berlin and William B. Weinstein, "The Montefiore Program: Psychiatry Integrates with the Community," *Mental Hospitals*, 14(January, 1963), 12.

way to provide proper treatment for the patients. This is not a luxury program; it is actually the only way in which we can obtain and maintain optimum discharge rates, minimum recurrence rates and true rehabilitation to useful citizenship for the patients who are our responsibility.

Sheeley,⁷ in an address to the New Mexico Medical Society, quoted Bourestom⁸ as follows:

"When a discharged patient fails to make a community adjustment it is found that failure is more apt to be due to community hostility than to continuing mental illness."

Since psychiatry must re-enter the community if a satisfactory number of hospitalized psychiatric patients are to re-enter the community, we should look at the sort of statewide program best suited for the purpose of achieving this aim. In the first place, the administrative structure which houses the state hospital and community psychiatric activities must be co-ordinated in such a way as to eliminate competition and facilitate communication. The hospital side must take the responsibility for arranging for hospitalization throughout the state, as close to the patient's home as is humanly possible.

While there may be some slight justification for the point made by some hospital administrators that separation of the patient from his family may be useful to both, there is scarcely any doubt that distance increases the difficulty in returning the patient to his home—(I would almost feel in terms of the square of the distance.) New

hospital construction should, in most cases, not be necessary.

Increased use of insurance plans will inevitably make it possible for middle-income and lower-income patients to be hospitalized in psychiatric units in general hospitals. (In Utah in the year 1960-61, 846 patients were admitted to the one state hospital and 2,039 were admitted to some five other hospitals scattered throughout the state.) If there are sufficient numbers of patients for whom the state must take the major financial responsibility, it should be possible for the state hospital to subsidize appropriate numbers of beds in private hospitals rather than to attempt to centralize all hospital care or to construct new units. This plan is now in operation in Las Vegas, Nev., (the one state hospital is 300 miles away) and is apparently quite successful.

In the second place, there should be no duplication of outpatient clinics whether they care for the general run of outpatient problems or provide follow-up care for patients discharged from hospitals. These clinics should be scattered widely throughout the state and should be closely tied in with the communities in which they exist.

In some isolated areas, traveling or part-time clinics would be useful, although we have found it advantageous to have at least one person who lives in the community and, even on a part-time basis, can provide some continuity between the visits of the clinic team. Whenever possible, members of the hospital staff and members of such training centers as are available should serve on the clinic team; the experience is especially valuable for residents.

Once these two major groups of activities are arranged for, the hospital-clinic administration can begin to develop some of the other facilities which have been found valuable in facilitating the patient's easy access

⁷ Sheeley, William F., "Family Physician, State Hospital and Community," an address to the New Mexico Medical Society, Las Vegas, N. Mex., March 11, 1962.

⁸ Bourestom, N. D., et al., "Prognostic Factors in Elderly Mental Patients," *Clinical Medicine*, 8(September, 1961), 1751-54.

to the hospital and his reintegration into the community. An important part of the whole project is the utilization of trainees, from whatever programs are available and in all the mental health disciplines, in all the activities under way. Only in this manner can these people be given sophistication in the work of a broad-based community program, and only thus can we expect to interest them in working in such ventures.

Care should also be taken to involve local physicians, including psychiatrists in private practice, in these projects; there is no reason why general practitioners in outlying communities should not be part of the mental hygiene clinic teams in their towns.

Since the family is often the key to success or failure in the return of the patient to his or her home, constant therapeutic effort must be directed at the spouse, parents or siblings. Home visits undertaken while the patient is in the hospital and after his return, will be extremely instructive to the therapist and should be helpful to the family. Sometimes recommendations as to living arrangements can help diminish the minor irritations around the home, and we have found public health nurses invaluable allies in this sort of endeavor.

Often during the hospitalization period, the therapist will elicit from the patient areas of frustration in his daily living, areas in which his social and cultural horizons can be widened and a vocational or recreational interest can be developed. Some of these can be started while the patient is still in the hospital. Occupational therapy departments can be used to advantage here, and they point the way to activities which can be further explored in hobby shops or in community centers after discharge.

The hospital itself can offer a flexibility of program—day hospitals, halfway houses and foster home placements can be ar-

ranged under the specific direction of the hospital, with the advantage that a patient can be moved from one to another in stages and can, if necessary, retreat without embarrassment or too much of a sense of failure. This is another advantage of having the hospitalization near home. Some of these transition placements can include a trial at working.

Certainly for male patients, occupational guidance and support is probably the most important of the return processes. Whether or not the employer has a personnel policy which guarantees the return of the "recovered" patient to his old job after discharge from the hospital, the return to the desk or workbench must, of necessity, be difficult. There are questions, inadvertent comments, observational periods, suspiciousness and a tendency to attribute any unusual behavior of any sort to a return of the illness.

We have, for two or three years, been making an attempt to ascertain the nature of any difficulties which arise in the return of discharged schizophrenic patients to their former jobs. Much depends, of course, on the nature of the work and the size of the firm. Some 60 per cent of the patients studied worked for small businesses where they made unique contributions; for example, a welder might be only one of many in a large company but would be the only welder employed in a smaller one.

After the period of hospitalization, 75 per cent of those returning to the same job are returning to the large companies, the remainder to the smaller businesses. It is our impression that part of this difference is due to the policies adopted by the larger unionized companies to provide protection to the sick person (hospitalization insurance policies, protective labor policies, etc.).

There is a relationship, however, be-

tween the employer in the small business and his employees which we feel can, and should, be strengthened by interviews with the patient and his boss both during the period of hospitalization and following the patient's return. There is much more personal investment, and a very supportive relationship could be developed for the returnee if the employer could be assured that clinical help would be immediately available, should it be needed.

In essence, then, the hospital-clinic team must manage the hospital-to-community transfer of psychiatric patients, utilizing

all available existing facilities and developing others where they are needed. There is no room in this program for insularity of hospitals, clinics, training programs or administrative arrangements.

Mental health organizations as well as professional agencies of all sorts can be enlisted to contribute their parts in this all-inclusive therapeutic plan. The end result must inevitably be the optimum use of existing treatments and the best possible chance to test and utilize newer treatments as they develop, and we owe this to the patients for whom we have responsibility.

The common grounds between psychiatry and religion

"The scientist's religious feeling takes the form of a rapturous amazement at the harmony of the natural law, which reveals an intelligence of such superiority that, compared with it, all the systematic thinking and acting of human beings is an utterly insignificant reflection."

These words are quoted from the greatest scientist of the century, Albert Einstein. The psychiatrist looks at the intelligence behind the natural law not only in amazement, but with the awesome responsibility of being an active part in research and in action with the highest achievement of the evolution of the natural law, which is the human condition.

The law can be defined as the relation between cause and effect as well as the link between matter and energy. It is the latter definition which encompasses all the group of biological sciences. The body expresses its functions, inasmuch as it is alive. An-

atomy and physiology are tied by the very existence of that fragment of the law which is Life. Religion calls it the soul. But the soul is the law itself; it is the synthesis of all the relationships of cause and effect between organs and function. The statement that the soul is the greatest gift of God to humans implies that the Law is the trace of God in the universe, inasmuch as it creates harmony out of chaos.

Psychology, whose very name comes from psyche, the soul, is that branch of biological sciences which studies why and how anatomy expresses physiology. But at the human level its manifestations are of a different order than with what happens with every other manifestation of life.

The unicellular organism already shows the three basic characteristics of life; namely, individualization, metabolism and

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reproduction. Metabolism, or the exchange with the environment, is meant to keep the existence of the individualized entity. Reproduction, the continuity of the species in time, is the teleological evidence of the fact that the autonomy of the individual and his belonging to a broader-than-individual entity are complementary and not opposite concepts.

Freud (*Beyond the Pleasure Principle*) has found that the ego and sexual instincts exist even in the unicellular being. While this can be traced throughout the vegetable and animal kingdoms, a new factor is brought in the human kingdom, and the evolution follows different lines and obeys different laws.

The ascending spiral of evolution in mankind is made possible by the action of specialized sections of the neuro-muscular system which have no counterpart in animals. A case in point is the brain centers of language, and the different development of the peripheral phonetic apparatus compared with the one of animals.

The power of abstract thought creates a new aspect of life. Only man is endowed with powers going beyond the preservation of the individual and the species. Memory, developed as it is at the human level, offsets the destructive and irreversible action of time by integrating past and present experience. Memory is the medium which makes mental life possible by creating continuity in the mental process. Criticism, selection and the ascending spiral no longer require the untold series of centuries of the natural selective process.

Articulate language, impossible without memory and without which memory could not be as selective and productive as the human level requires, extends the conquest of thought to become a reality beyond the limit of the sensorial fact and the immediate experience. Through articulate lan-

guage, abstraction becomes the starting point of new conquests and new realities. Knowledge extends and intermingles sensorial and abstract fields. Abstraction is the synthetic capacity of facing various aspects of the truth to be conquered. The human mind does not create abstractions from concrete facts, but it discovers already existing abstractions through a more focalized study of sensorial facts.

So the self-propelling capacity, the very essence of the human condition, is born as the synthesis of abstract thought and articulate language. The tridimensional aspect of psychology—time, space and depth—evolves from the inception of life to the human kingdom and from there to the evolution beyond the human level.

In space, metabolism (or the continuity between organism and environment) becomes articulate language, which transcends the distance between humans. In time, reproduction becomes abstract thought, which transcends the distance between generations and insures continuity of every human endeavor. In depth, individualization is finally identified with the self-propelling capacity. Beyond the human level, the three theological virtues extend the same process: charity is extension in space, hope in time, faith in depth.

The difference in the learning process between animals and men better illustrates the peculiarity of the human kingdom.

Learning is the art of creating reflexes. Reading, as an example, is an acquired reflex, which establishes the arbitrary relationship between graphic symbols and sounds outside the realm of conscious attention, so that attention is freed to be concentrated on the content of what is read. Physiological reflexes are an endowment of living organisms that were organized through millions of years and became inherited conditions.

Conversely, the educational reflexes must be repeated for each individual, but their intensity is so much greater that in a short span they accomplish their action, to be superseded by more perfected and farther-reaching educational reflexes. The intensity of the ascending spiral is in proportion to the flexibility with which educational reflexes are outlived and substituted by more focalized reflexes.

Animals, under very special circumstances, are capable of learning beyond their self-training capacity, if trained by men, while man has the ability of training himself for future conquests. The best trained rat cannot show another rat how to orient itself in a maze. Conversely, the discovery of a genius becomes in a few years the endowment of every human being. Furthermore, the span of attention of an animal does not reach beyond the immediate sensorial world. The most evolved animal will never be taught the existence of a distant country. A child of mediocre intelligence, whom a trained animal could beat on grounds connected with its training, will be able to conceive the existence of a country that does not correspond to any sensorial experience. The difference between animal and man is of quality, not quantity.

Comparative anatomy provides the evidence that we are in the middle of an evolutionary process. As an example: the structures that will develop into the Broca and Wernicke areas in the human brain are rudimentary zones in the ape's brain. An experimental lesion in such sketched areas is not followed by detectable symptoms. When we think of the vast extension of "silent zones" in the human brain, we can entertain the hypothesis that they are areas for the development of future functions, as unknown and inconceivable to us as articulate language is to the ape.

Every aspect of the evolution from the animal to the human kingdoms is a conquest in the field of abstract thought. Millions of years separate the brain of the ape from the brain of man. Similarly, millions of years separate the beaver's hut from the Cathedral of St. Peter's, the beehive from the British Commonwealth and the performance of the Elberfeld horses from the theory of relativity. But the difference is not merely structural. It is inherent in the motivation.

The beaver builds a hut with no other aim than to provide shelter for himself against cold or storms. Shelter from cold or storms is not the purpose of a church, a school or a court house. And such buildings convey to each one of us a much deeper sense of security than individual dwellings do. Religion, knowledge, right under the law, protect us against dangers which are not of the sensorial range, but which we recognize as much more destructive than cold or storms.

The psychiatrist is called upon to deal with this essential aspect of the human nature. Psychiatry is that branch of medicine which is concerned with the partial or total loss of what makes the endowment of the human kingdom. The impairment may or may not allow continuation of life in a community; it may be brought by organic or emotional factors; it may be primarily linked to the mental or the emotional aspect of the personality; in every instance, psychiatry is primarily concerned with the errors in those powers which go beyond the preservation of the individual and the species. As cases in point, psychosomatic and psychosexual causes and symptoms would not have their peculiar characteristics if such areas in man were not conditioned by the peculiarity of the human level of evolution.

The plant, even if perfect in every part,

dies when its roots are severed from the earth. The human being, even if physically fit for life, is severed from his very essence when his mental and emotional lives are not rooted in its vital ground, that lifeline to abstract thinking, to conscious command of intellectual powers, and to the awareness of the reality of ethical concepts which only can ensure harmony in dynamic growth. The abstract world is as indispensable to man as the earth is to the plant.

Here is where religion and psychiatry have their most productive common grounds.

Two essential points are brought forth by teachings of every religion. One is that the evolution of man is limitless. The other one is that man is not his own goal, but his tool along the path of evolution for a goal which is beyond the boundaries of humanity. The narrow circle established when the individual is his own goal precludes that amount of freedom from past limitations which makes relapses impossible.

The goal of therapy is to re-establish a dynamic flow that will enable the patient to face the future with self-reliance. Destroying the carryover of the past is a means to a wider goal. Therapy is successful when self-propulsion is firmly reconditioned for life, under any unforeseen circumstance.

Guilt, in many cases both the crippling factor and the incentive toward therapy, could be better handled by the psychiatrist if faced with the religious concept of the role of guilt in humans. The only constructive form of guilt is what religion calls "Fear of God."

It is the realistic concept of man's weakness compared with efforts and achievements along the road to evolution. It cannot breed frustration because it is turned

into the constructive attitude of learning through mistakes. It is realistic inasmuch as it frames weakness where it really belongs; namely, as a warning of the existence of a better approach to the same problem at a following stage of evolution that can realistically be met.

Guilt is the expression of the fact that the present steppingstone can be outgrown. The awareness of the cause of the mistake makes it clear that the mistake can be avoided, thus framing the cause into the broader aspect of being a step in the evolutionary process. The fear of God breeds hope, which is the awareness of the reality of the next step lying ahead. Fear and guilt belong to the repetitious and unconstructive past; the fear of God looks toward the future, and therefore guides the present. It does not always succeed, but it is the best possible opportunity.

The guilt tied to the superego builds the awareness of ethical principles and paves the way to a constructive pattern of life. But the superego is merely a steppingstone. Religion shows the existence of a new level of development at which guilt is completely severed from anxiety and pain. The term "beyond-ego" is suggested to indicate the stage at which the individual has outgrown the danger of relapses, because this level of emotional acceptance is only compatible with no pain and anxiety in guilt.

Past and present mistakes, and anticipation of future mistakes create no more distress than success creates elation. These steps are equaled in their value as soon as the focalization of attention shifts from an individual to a broader-than-individual point of convergence.

As long as an individualized goal exists, the danger is that the goal may be lost and nothing left to replace it. Within such limits, nobody is beyond the range

of a possible recurrence of his vicious cycle. Too many humans act like a prisoner who climbs over the prison wall and thinks he is free, only to find himself in a wider courtyard of the same prison. Escape from the prison would entail giving up the pursuit of happiness through individual achievements and personal gratification. Real sublimation is clear from the danger of relapses when it breaks the barrier of the superego and reaches the level of beyond-ego.

The common grounds of religion and psychiatry extend also to the field of mental prophylaxis, mostly in regard to education, where religion is an irreplaceable factor. The emotional background from which ethical conceptions develop is a reality long before the child's mind is set for rationalizations. When the age for intellectual explanation comes, the emotional pattern is already set, and it takes more

than the cold notion of good and bad to create an indestructible foundation for ethical life.

Sensorial religious symbols impress the very young child with the existence of something beyond the range of everyday life. A tangible object, disconnected with daily routine, commands the respect of the omnipotent adult. In later years, the way is paved to accept religious principles for what they are; namely, an attempt to give meaning and unity to life beyond the narrow range of immediate experience and personal interest. This unshakeable foundation is the root of inner security.

Co-operation between the two disciplines will require extremely thorough study and investigation. From the recognition of the common grounds, a new philosophy will mature through prolonged research and experience. The time is now.

Developing consultation relationships with community agents

INTRODUCTION

Consultation is one of several services provided the community by the Mental Health Study Center established in Prince Georges County, Md., in 1948.

As a demonstration community mental health program, the center, throughout its history, has had an orientation based on public health philosophy. This philosophy addresses itself to a population or com-

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¹ This is not meant to imply that this approach is new. Actually, it seems to represent a renewed interest in ideas that were applied in clinic practice as far back as the early nineteen twenties. For a most enlightening discussion of the use of consultation, collaboration and various educational means to strengthen community resources in early clinic practice, see: Stevenson, George S. and Geddes Smith, *Child Guidance Clinics, A Quarter Century of Development* (New York: The Commonwealth Fund, 1934).

munity-centered approach, wherein all possible channels within a community are utilized to reduce mental illness and to promote healthy personality development.

Complementing this philosophy is a recognition and acceptance of the relevant sociocultural environment of the individual and the importance of understanding this environment and the individual's use of it in order to deal effectively with community mental health problems.

This approach departs somewhat from the more traditional clinical approach to diagnosis and treatment, in which mental health problems, to a greater or lesser extent, are viewed in terms of intrapsychic conflicts and psychopathology.¹

Operating within this framework, the study center has endeavored to cultivate community relationships and to strengthen community resources by extending its services to the community in a variety of ways. One is the utilization of an intake policy which effectively combines clinical services

with consultative activities. With this approach the study center has been able to focus its attention on the "functional community" (the "help-giving" community, comprised of those professionals who in their daily practices are called upon to assist individuals in difficulty; e.g., teachers, physicians, probation officers, welfare workers, ministers, nurses, etc.) toward developing satisfactory interprofessional and interagency relationships and using these relationships in the promotion of mental health goals.²

The purposes of this paper are: first, to record some of the writer's observations on developing mental health consultation with community agents through the extension of clinical services; and secondly, to discuss the use of collaboration as a consultative tool; i.e., a device to assist in establishing a consultative relationship.

Since the study center operates from a clinical or "service" base in providing psychiatric treatment to residents of Prince Georges County, it is believed that the problems with which we are confronted in learning to penetrate the "help-giving" community are, in many respects, similar to those faced by any mental health clinic that: (1) is concerned with the impact the clinic is having on the total population which it serves; and (2) has attempted to extend its services to the community through the provision of consultation services to community agents. Hence, it is hoped that this paper will stimulate others to experiment with different ways of reaching community agents, and perhaps to reject, confirm or modify some of the ideas here expressed as being applicable in their own settings.

EXTENDING CLINIC SERVICES

Most mental health workers would probably readily agree that it is one thing to

provide consultation services to a community agent who is sufficiently sophisticated to know when and how to ask for it; but it is quite a different matter to attempt to reach out to certain professional groups who have not asked for consultation help, and who have not yet reached that point in their professional development of assessing the emotional and psychological needs of their clients.

Included in these groups are general medical practitioners, visiting teachers, attorneys, welfare visitors, police officers, nurses and so forth. Although they are in constant contact with a large segment of the population, and although they deal daily with a wide range of problem situations, they are, in many instances, not wholly aware of the mental health implications of their roles, or of the mental health implications of the problem situations with which they provide assistance. Being unaware of the possibility that they could be even more helpful to their clients, they do not seek help from a mental health consultant.

The problem then becomes one of learning how to work with these agents in order to help them to find meaningful ways to integrate mental health practices into their basic professional operations. Rooney has spelled out a number of methods commonly used to this end; e.g., referral conferences, seminars, institutes, agency inservice training programs, group meetings and so forth.³ However, he has also indicated that while these methods are certainly valuable and are not to be minimized, they do not offer a means of establishing an enduring relationship, through which a mean-

² Rooney, H. L. and A. D. Miller, "A Mental Health Clinic Intake-Policy Project," *Mental Hygiene*, 36(July, 1955), 391-405.

³ *Ibid.*, p. 394.

ingful helping relationship might eventually evolve.

The method developed by and currently in use by the center is that of a professional referral intake policy. In terms of clinic operations, this policy means that clinic patients are referred exclusively by professional agents in the community. "The ultimate decision of patient selection should rest with the clinic staff best qualified to determine the appropriateness of their services for a particular problem.

"The preliminaries to this decision require that the agency or individual professional discuss the problem with the clinic; this requirement, in essence, becomes an automatic, informal, enduring consultation process which, as part of intake policy, can supplement other consultative-educational programs of the clinic."⁴

The use of this policy over a period of years has resulted in the center's establishing at least a telephone relationship with all referral sources. "This has facilitated the center's use of these services in better preparing the patient for clinic service through interpretation, medical workup, focus of the problems, and co-ordination of agency programs able to help the patient."⁵ In addition, it has resulted in an increased use of consultation time by the agencies to discuss situations not being considered for referral.

It is this latter point; namely, the increased use of *consultation time* by agencies to discuss situations not being considered for referral, which concerns us in this paper. That this has actually happened can be attested to by the many practitioners who have been involved with the policy over the 10 years it has been in operation.

There is also some empirical evidence with one particular agency, the school system, which throws added light and lends support to the statement. For example, during the 1960-1962 period, of 100 contacts by this agency, 43 were for the purpose of conferring with clinic staff about problem situations not being considered for referral. We do not have the same sort of data on other agencies at the present time, but we are in the process of conducting investigations which will provide further information on the extent to which this condition actually occurs.

Assuming for the moment, however, that the use of a professional referral intake policy does result in an increased use of consultation time by community agencies, I should like to discuss in further detail the procedures utilized and also to point out some of the errors we have made and the lessons we have learned along the way.

BUILDING A RELATIONSHIP

Developing a helping relationship from an initial telephone contact is complicated by several factors, not the least of which are the expectations and perceptions the community agent has of the mental health center at the time the contact is made. This is mainly one of the center being a place staffed by professional clinicians who provide psychiatric treatment to people with mental health difficulties. Many have little understanding of the center's role in prevention and, as we have pointed out earlier, few have much awareness of the mental health implications of their roles as professionals. Hence, they primarily call to refer; they do not request consultation.

It is at this juncture that we have erred in the past. Realizing that the routine use of the professional referral intake policy over a period of time had increased some-

⁴ Ibid., p. 395.

⁵ Ibid., p. 398.

what the use of mental health center staff for consultation purposes, we decided a few years back to utilize more systematically our contacts with community agents to focus upon consultation. This meant that when we were contacted about a referral, we would attempt to de-emphasize our clinical role and to accentuate the consultation aspects of our function. In so doing, we were saying in effect, "we cannot accept your client for treatment, but we are prepared to work with you in planning alternative courses of action."

We would purposely put off any discussion of referral, not considering it one way or another, attempting at the same time to explore with the community agent ways in which he might continue to work with the client, limiting our role and services to that of a consultant. There were, of course, some exceptions to this approach, but in general this was the procedure we followed.

The result was rather intense dissatisfaction on the part of the community agents; they felt on the one hand it was extremely difficult to have a patient admitted to the center for clinical service, and on the other that the center staff frequently attempted to have them [the community agents] continue with a client after they themselves had already become convinced of the need for some type of more specialized treatment. At times the community agents would perfunctorily carry out suggestions made by the center staff, only to follow this up with a further request for referral at a later date.

In any event it seemed apparent that, by and large, the community agents had not been able either to accept or utilize the proffered "consultation," as we had hoped they might. Although the reasons for this may now seem obvious, it was only through rather painful self-searching that

we finally reached the conclusion that by offering consultation in this manner, we were often not responding to the community agent's perception of us, or to the type of expected assistance, but rather to our own preconceived notions of how he should or could be more effective in performing his role as a professional person.

As a result of this painful learning experience, our objectives have continued more or less unchanged; however, we have revised our way of working with community agents. The general policy is still one of encouraging the community agent to maintain control of the case whenever this seems advisable; however, the assistance offered is now more closely related to his needs and expectations.

When we are contacted about a case, the first step is to confer with the community agent in a face-to-face situation, when practical, or not, through a telephone conversation, before any decision is made about the problem. These conferences are used to gain as complete an assessment of the client's history and family situation as possible, to evaluate the nature and extent of the present difficulty, to determine whether or not there are other community agencies involved in the situation, and to get some understanding of the relationship the community agent already has with the client.

On the basis of this information, we then try to determine jointly with the community agent whether or not some type of psychiatric intervention is advisable. Throughout this process we emphasize our interest and willingness to work with the community agent in dealing with the problems involving his client, and whenever possible we attempt to keep the focus of responsibility on the community agent, unless of course this is contraindicated.

There are some instances where the

community professional indicates such a lack of interest in handling a case that, in the interest of the client, we will intervene and accept the client for service. However, even here we make some attempt to keep the community agent posted on the status of the client through periodic follow-up reports, particularly when we know that he will from time to time be in contact with the client. In most cases, however, we do not disrupt the relationship between the community agent and the client; rather, we attempt to maintain it by carefully exploring and fully clarifying the role we will have in the case and spelling out in detail the extent to which he will continue to participate in a comprehensive plan which is arrived at jointly around the client's needs.

By including the community agent in a joint treatment plan, we continue to maintain a means of working with him, and of equal import, we are able to utilize significant elements in the client's socio-cultural environment in a way which facilitates the clinic services provided. A good example of this is our work with the schools. Since a child spends a major portion of his day there, the school automatically exerts a great influence on his welfare. Hence, by working jointly with school personnel around a common problem, much can be done to facilitate the course of treatment, as well as to enhance the efforts of the school personnel in their work with the child.

The methods used in working jointly with community agents around a particular client's needs are quite varied, ranging from a psychiatric evaluation and the reporting of our findings and recommenda-

tions regarding further care of the patient, to rather extensive collaborative endeavors lasting for several months.

CASE ILLUSTRATION⁶

In one situation a worker from a local agency worked with a young boy while a staff member from the study center treated the boy's parents. The worker had referred the boy to the center because of his belligerent attitude toward parents, teachers and others in authority positions, his dirty and unkempt appearance, and his complete lack of co-operativeness in her attempts to help him. Although she could have requested consultation, she sought referral instead and the case was handled on that basis.

Following an evaluation of the boy and the parents, in which it was felt that much of the boy's problem was reactive in nature to a rather disturbed family situation, a plan was developed for the parents to be treated at the center, while the worker concentrated on the boy and his relationships in the community. Periodic conferences between the center staff member and the agency worker were held throughout the treatment period. It was in these conferences that the relationship between the staff member and the agency worker developed.

From the beginning, the worker's efforts to help the boy had consisted of rather persistent attempts to make him conform. Also, she had identified rather strongly with the child's mother and teacher and remarked in one of the early conferences that it was practically impossible for anyone to put up with this boy for more than one or two hours at a time.

The staff member from the center worked toward establishing a supportive relationship with the agency worker. He accepted her feelings and opinions, and confined his remarks to understanding the boy's behavior, through his knowledge of the family situation. At the same time he tried to gain more of a feeling for the relationship which existed between the worker and the boy, as well as her relationships with others in the community with whom she was working; i.e., the teacher, a playground leader, and a church official.

One theme which seemed to recur over and over in the conferences between the staff member and the agency worker was related to the

⁶ This illustration is representative of our work with community agents, but is not an actual case record.

boy's dirtiness and his lack of neatness. This particular problem seemed somehow more significant to the worker than many of the other complaints which had been presented. Although the staff member wondered about the meaning of this particular characteristic to the worker, it was never openly discussed with her, even though considerable time had been spent in discussing the family's attitude toward cleanliness.

Also, it was pointed out that the father, who worked in a garage, frequently came for clinic appointments dressed in dirty work clothes and smelling of oil and grease. The center staff member was not critical of this and made particular mention of it in order to indicate that the father was as acceptable in this dress as he would have been had he been dressed in a new suit.

At one point in their work together a co-ordinating conference was held bringing together each of the persons directly involved with the child—the teacher, playground leader, and the church official who had the boy in a children's Bible discussion group. During the discussion it became evident that the boy was making a fair amount of progress in several areas of his functioning, although all agreed that there was still much to be done. One outstanding feature of the conference was the lack of any reference to the boy's physical appearance or dress. The staff member was aware of this but did not comment on it. Toward the end of the discussion, however, the worker remarked about it and for the first time wondered aloud if this wasn't a problem that she was more concerned about than anyone else.

This seemed to be a turning point in the case, for there was no further mention of it and from then on the worker seemed to move ahead, making plans and working them out with the boy and the community. The boy continued to manifest some of the same difficulties originally presented, but he was no longer the "problem" he was in the beginning. Furthermore, the worker became much more at ease in expressing her feelings and views, and continued to bring in cases for discussion. Thereafter, it was much easier to come together and confer about a case and the agency worker seemed more willing and able to work out and implement a plan during the consultation, without the need for referral.

Other types of collaborative work with community agents have taken place. In one case a school principal was included as a participant with a family undergoing family group therapy; in another, a staff member treated a child while a welfare worker counseled with the parents in the home. Not uncommon are co-operative arrangements with physicians who administer medications and conduct physical and laboratory examinations while the patient is treated psychiatrically at the center.

Regardless of the method used, we have found that working collaboratively with the community agent offers much toward building a relationship which frequently lays the groundwork for the establishment of an effective consultation relationship. It also benefits the client both directly and indirectly, but of greater importance here, it offers a means of assisting the community agent in the application of sound mental health practices in his work.⁷ Not only does he become psychologically closer to his patient or client, but opportunities for his viewing the manner in which the mental health worker perceives the patient and his problem are frequent.

The alert worker can utilize these experiences to gradually encourage the community agent to become more active in expressing his own views of the patient. A discussion of these perceptions can be a meaningful learning experience.

Another important factor is that opportunities are ever-present for providing emotional support to the community agent. This, of course, is not done in a therapeutic way, for the level of the relationship is never as intense as it is in therapy, and the focus is always on the client. Rather, it is accomplished through the mental

⁷ Stevenson, Smith, *op. cit.*

health worker's acceptance of the community agent, his respect for his capabilities, and the approval he is able to give, all of which operate to encourage and assure the community agent of as many positive and satisfying experiences as possible.

Finally, the community agent is not asked to carry out somebody else's plan, for which he feels ill-prepared or poorly equipped, or for which he questions the utility value; rather, he participates fully in a relationship with another person, which for him, through the assistance he obtains from the mental health worker, has personal and professional significance. In this manner he gradually gains a greater understanding and awareness of the emotional aspects of his work with clients; he also develops a greater respect for his own ability to contribute to the handling of mental health problems on his own level of practice.

When this has occurred, a meaningful working relationship has been very well-established. It would then be possible for the mental health worker and the community agent to begin thinking and talking together about relating on a level approaching that of "pure consultation" without encountering the type of difficulties

mentioned earlier, for the community agent would by then have begun to modify his perception and expectations of the mental health worker and the agency he represents.

He will have realized a greater sense of responsibility for the mental health problems of his community, increased his skills in participating in their solution, and will be more ready to request, accept and utilize help in the form of consultation from the mental health agency.

When used in this fashion, collaboration becomes a way of demonstrating to the community agent the manner in which the mental health specialist works with a patient; it contains a strong educational element which contributes to the professional growth and development of the community agent. Finally, it facilitates the development of a helping relationship, out of which a working consultation arrangement can eventually evolve.

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The mental health professional in the community: Some generalizations for effectiveness

In our eagerness to implement the community-based programs which hold such promise for the future of the mental health movement, there are certain pitfalls we cannot afford to overlook. The conviction that the community can and will provide a broad spectrum of psychiatric services, in conjunction with services provided by professionally staffed treatment facilities, assumes mutual co-operation and respect—a partnership between the professionals and the community.

Not only must the mental health professional be competent within the sphere of his clinical specialty; he must also become aware of the sociological, psychological and anthropological aspects of his new partner if he is to communicate and provide effective leadership. Without such effort on the part of the mental health professions, the stage becomes set for misunderstanding, distrust and disillusionment.

These are a number of generalizations

which might have merit in guiding the worker in his dealings with the community. Some have been drawn from the social sciences, others from experiences in attempting to stimulate community programs at the state level (1, 2). It may well be that an entirely different set of generalizations could be developed as guidelines for those in the mental field who live and work within a community setting.

These generalizations could provide orientation for mental health personnel entering the community health area. To those experienced in community mental health, these generalizations may serve as stimuli for the development of more meaningful guidelines or principles.

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(1) Mental health professionals with rare exception, comprise a subcultural group, and, therefore, do not have communication-access or opportunities to influence the total community.

The knowledge, values, ideals and goals of the professional (the hoped-for outgrowths of his training) may evoke admiration and feelings of affection from some segments of the community, while evoking awe and fear from others. Such varying reactions are probably specific as to time and cultural setting (3). To assume that the professional mental health worker—because of his status and competency as a psychiatrist, psychologist, social worker or nurse has automatic community respect and acceptance appears hazardous.

(2) Community leadership is often vested in a few key individuals who are not always prominently visible.

This second principle is derived from sociological studies of community leadership (4, 5). One of the initial tasks confronting the professional attempting community organization is the identification of this core of "natural community leadership."

"Contrary to the sometimes voiced opinion that most community leaders are crusaders for mental health because of personal difficulties, leadership appeared to emerge from already established influential figures in the community whose civic responsiveness had been previously demonstrated" (2).

Once this identification of "natural community leadership" has occurred, the professional is faced with the task of understanding the community's perceptions of its mental health problems, its proposed solutions and goals. To integrate professional solutions and goals into this process is a test of the professional's effectiveness.

(3) A community's "threshold of hearing" varies according to the community prestige and demonstrated civic responsiveness of the speaker.

This generalization evolves from previous principles, but holds enough importance for the mental health worker to warrant special mention. The same words uttered by a visiting mental health professional may have entirely different meanings when said by an established community leader. The mental health professional entering the community from the "outside" is usually seen as having a definite intention to persuade; he is, therefore, perceived as having something to gain. Such impressions do not facilitate trust (3, p. 23).

(4) Ultimate program decision-making occurs at the community level and comes to fruition only over periods of time.

Harking back to the concept that the community is a partner with the professions in establishing and maintaining community mental health services, the professional must then accept the partner's right to accept or reject his proposal. This does not imply that the mental health worker is passive during the community's decision-making process. On the contrary, the professional uses every educational device at his disposal to influence the community's decision. If the community makes the "wrong" decision, this also must be accepted by both community and professional. Decision-making carries with it responsibilities for its consequences which the community must be helped to accept.

(5) A community, like an individual, follows its own unique path of growth and development.

This generalization seems almost trite, but it is a source of constant frustration to state level personnel who envisage a

statewide network of community services, and then encounter lagging individual communities.

(6) *The professional's role in the community process is one of "facilitator" rather than "manipulator," requiring a high degree of confidence in the community's capacity to grow, to learn and ultimately to repair its own insufficiencies.*

SUMMARY

With the realization of the tremendous contributions that community-based mental health programs can make to the mental health movement, some generalizations have been set forth as guides to the mental health professional. It is hoped that these generalizations may serve as stimuli for the development of more meaningful prin-

ciples which appear to be needed if our professional goals and expectations are to be realized.

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HELEN PADULA, M.S.W.

Foster homes for the mentally ill

Foster care for the mentally ill is not a new therapeutic invention. It existed long before psychiatrists, social workers or mental hospitals were thought about—long before psychosis was recognized as illness.

Foster care has its origins in a legend. Dymphna, an Irish princess, fled with her priest to the town of Gheel, Belgium, to escape the amorous advances of her demented father. There the king overtook and slew them both. On this spot a shrine for the mentally ill arose. During the Middle Ages its healing powers were sought by pilgrims from all over Europe.

Not all found relief. Some remained in Gheel, finding shelter with the towns-

folk. Gradually, the few became many. The odd, the tormented, and the deluded were no longer unusual, or frightening. The villagers learned to absorb these strange folk into their families. While the insane in other parts of Europe were "put away," manacled in dungeon-like institutions, the mentally ill in Gheel lived on intimate terms with the townspeople, cared for but also contributing.

Similar programs were initiated in many parts of Europe and in America following the discovery of Gheel's fortuitous venture. Thousands of patients who might have lived out their lives in psychiatric captivity were able to leave the hospital under the auspices of foster care programs. For some patients, placement produced amazing transformation; withered spirits revived and unsuspected abilities blossomed. The results were less spectacular for others but were still cogent demonstration that the mentally ill, like people with heart trouble

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or tuberculosis, do not need to remain confined until all handicap disappears.

Foster care programs vary. I speak, of course, from the Maryland experience developed by Henrietta DeWitt, where foster care is an integral part of hospital service. No plan, however much admired, can or should be taken over lock, stock and barrel. You will, of course, develop your own pattern. Your base is already different. The county welfare departments in your state are charged by law to provide assistance to patients who cannot return to their families. In spite of many other responsibilities, you have already tackled this new task with imagination.

However, because your base is the community and not the mental hospital, you probably feel uneasy that you know so little about mental illness. The burghers of Gheel knew even less. The heart of any foster care program is not psychiatric sophistication—whatever that may add—but human warmth, shelter, acceptance and status for the dispossessed.

Because the mentally ill have been ejected from society and set apart in remote, isolated communities called mental hospitals, their difference has been overemphasized and the qualities they possess in common with all of us have been obscured. I will not presume to tell you how to run a foster care program, but I will borrow from my greater experience with mental patients and the state hospital world to describe the human problems patients face and, therefore, what considerations have to go into a foster care program.

I would like to bypass pathology. Mental illness is not like other illnesses: its presence is evinced in distortions of behavior. The mental patient is unlike himself—and therefore suspected not to be himself and perhaps not human in any sense that we can understand. Pathology becomes a cos-

tume. Like the painted face and baggy pants of a circus clown, the mental patient's symptoms obscure the human being.

The student social worker, new to the hospital, asks anxiously, "How do you talk to a schizophrenic?" The experienced family agency worker freezes when she discovers that the client she has been helping, as she would anyone else, is a convalescent mental patient. Even the general practitioner called to treat an infected toe regards the infection beyond his medical ken if the toe belongs to a former state hospital patient. Nothing so jeopardizes membership in the human race as the diagnostic label of psychosis (and especially if, having been ill, that person has at one time sought treatment in a state mental hospital).

So let us put symptoms aside for the moment and talk about the people who now live in the state hospital. Many of those whom you will be asked to help have lived there for years.

Who are they? They are a cross-section of any community. They are well-to-do and poor, learned and illiterate, young and old, pleasant and disagreeable, hard-working and lazy. They bear a diagnosis that seems shameful and frightening to themselves as well as to family, friends and neighbors. They have been away from the world for a long time. They have been separated from family and friends until once vital human connections have ceased to exist in any meaningful way. Meanwhile, they have adapted to a world whose mores diverge widely from those of the world outside.

Consequently, when patients seek to re-establish themselves in the community, they are oversensitive to what people will think of them; they are tense and awkward in unfamiliar surroundings; they are lonely; and they are unwittingly bruised by unexpected reminders that the adaptation

they achieved in one culture is not appropriate to another.

These problems are not new to you, are they? Minority groups are painfully aware of their difference; soldiers readjusting to civilian life feel restless and out of place; old people are often bereft of family and friends; and refugees contend with a cultural abyss between the old and the new.

You may think that the patient's problem in crossing the cultural abyss is primarily a question of catching up with the changes that have occurred in the outside world since his hospitalization. And that is some of the problem.

After 40 years in Spring Grove, one old fellow was helped to select a suit in preparation for release. He admired it very much but doubted if he would look quite right without a celluloid collar. And then, although reassured by comparison with visitors, physicians, etc., he still did not wear the suit. He didn't because he could not get the hang of this new fangled contraption to close his pants—he had come to the hospital before the invention of zippers! Supermarkets, dial telephones, buses and even the looks of the once-familiar city take some getting used to after 20, 30, 40 years. One patient left after 58 years!

The patient is not just re-entering a world that has changed. He is not the person he was on admission. He is a cultural as well as a medical casualty. He has gradually, almost imperceptibly, taken on the mores of the mental hospital society. You would expect to prepare an immigrant from an Eastern European hamlet for the complex adjustment to American manners and customs. But the patient is an American, a resident of this state before his hospitalization.

Let me describe briefly the kind of world in which he has been living. The hospital is a society of sick people. They are not

all alike, of course. But the hospital is an asylum for those who, for many different reasons, have not been able to get along in the community. It therefore offers an accepting climate for deviance. Unfortunately, only a fine line divides tolerance from habituation. Finally, neither staff nor patients see how different patients have become.

The difficulty is compounded by deficiencies in staff, equipment, living space and activities. Mental hospitals have improved enormously in the last years, but improvement is concentrated in admission and intensive treatment services. The chronic wards, from which many of your patients will come, are too often still crowded, bleak and monotonous. In any case, the patient admitted five, ten or more years ago received his conditioning from a custodial care era.

Too few staff means little individual attention is possible; days run idly and meaninglessly into one another. With nothing to do, part of a milling crowd, unable to find any privacy, the patient can only turn inward for solace or quiet. What flicker of interest he may have had in his neighbors soon dies to the point where he may not know the name of the person who occupies the bed next to his. What flicker of self-respect he may have had is soon dimmed by the shapeless clothes he wears, the lack of any storage space for possessions, the absence of niceties—wash cloths, napkins, doors on toilets, mirrors, clocks, calendars—and by the regimentation of his day. He lines up for meals, movies, baths. He is called by his first name or a nickname.

I still remember how surprised we were many years ago to receive an urgent call from a careholder to come immediately for the patient recently placed. They had wanted to live together. The patient was

never difficult, only at one time depressed. But now, according to the careholder, she would not eat or bathe. We talked to the patient, and learned something. She had wanted to sit down to meals with the family, but the sight of knives and forks, after countless years of dependence on spoons for eating, terrified her. She had wanted to take a bath but for years the taps had been turned on and off by the nurse: suppose she should not be able to stop the water!

I do not think she was saying that she could not handle cutlery or faucets, but that she might seem stupid or awkward, or might make trouble. To a tense, burdened human being these apparently trivial difficulties can seem overwhelming.

Let me mention just a few other common sources of difficulty. A room to oneself in a silent, sleeping household may cause panic after nights spent in huge dormitories with an attendant on watch and a night light burning.

Food assumes enormous importance in the monotony of hospital living. To find it freely available triggers the need to gorge, to raid the ice box. Table manners are forgotten amenities in the large, noisy mess halls of chronic wards.

A walk to the corner mailbox may be an enormous undertaking after confinement behind locked doors.

Hospital rhythm for waking, eating and retiring is out of gear with the pattern outside. These habits are hard to readjust. When a patient begins wandering around the house at 5:00 A.M. he disturbs the family; he also worries them unless they understand.

The capacity most damaged is initiative. Nothing so disrupts institutional routine as originality. Compliance and withdrawal have been necessary adjustments for self-protection until the patient almost for-

gets that he has any wishes, and he certainly does not voice them.

Because the patient feels that his illness is shameful; because he has been for so long an object of rather than a participant in his care; because he has been powerless in a setting where so many people have the right to control him; and because he has been submerged by routine and mass living, he loses all sense of self. He is absorbed into a category: chronic mental patient.

Successful foster care placement has to take into account the consequences of these experiences.

First, the hospital social worker will help to prepare the patient for some of the expectations of society: to dress appropriately, shave and bathe himself, try himself out in hospital industry if he is planning to work, encourage him to expand the narrow confines of his living but mostly to begin thinking about himself again as a person with opportunity to make choices.

Would it be possible for him to come to your office for an appointment or two before he leaves? He will gain experience with public transportation and some of the edge will wear off the uneasy feeling most patients have that every passer-by recognizes immediately that he is a patient from the state hospital. He can also talk to you about the kind of placement he wants and can get to know you. You are his one stand-by if things go wrong. Furthermore, you will find that a home for someone you know is much easier to find than a home for a "mental patient."

Second, if the patient is to make an adjustment outside he will have to become a person, not remain a patient. His placement should allow some ready-made and appropriate role: grandfather, handyman, star boarder. That role should not compete with an already established role in the

family group. Think how difficult two natural grandmothers, for instance, can be who have no question about their identity!

In Maryland our limit is two patients to a private family. No family can assimilate more strangers without unwittingly separating them into a category.

Third, foster care is not a form of medical treatment. It is intended not to provide nursing or custodial care for someone who is sick, but an opportunity for living for someone who may be handicapped but is no longer in need of hospital care. Because of the locus of symptoms in this illness, it is difficult to disentangle the two. People, including the patient, are anxious about mental illness. But patients can be angry without being paranoid, may grieve without being depressed, and may misunderstand without being out of contact.

No outsider can enter a family group—even a relative or friend—without misunderstandings and tensions. Too often these normal adjustments are seen apprehensively as indications of relapse. A man may be hurt and sulk without necessarily being psychotic; an old man may wet the bed at first, from anxiety, without being regressed.

Fourth, patient and careholder need encouragement to talk over their difficulties with each other. Each will tend to look to you for intercession. How will the patient learn if he does not get direct reactions and if he is assumed incapable of handling problems?

Fifth, no patient should have to stay in any particular home although he may have to live in a certain *type* of setting if the doctor so advises. Any medical restrictions should come to you explicitly from the hospital. For instance, a woman who easily becomes confused should not be left at home alone; she might start to brew herself a cup of tea and forget to light the

gas. A man who causes difficulty with his family should at first live at some distance from them until he shows that he can manage.

And last, since foster care is a period of convalescence for people who have had some difficulty living with others, no foster care placement should isolate the patient. Occasionally, farmers provide a little shack on the grounds. And the patient may be glad to be left alone. Such living will not help him and invites abuse or neglect. The intimacy of a family group may be more than some patients can manage; isolation is not the only alternative. You may have residence clubs, YMCA's or jobs in small institutions with live-in arrangements which often offer a good transition for the employable person from patient to employee status.

Let us come back for a moment to illness, a subject you generously agreed to put by. Many of these patients will have residual symptoms although they will not be considered dangerous. Medical science has gone as far as it can presently go to cure them. They simply have handicaps.

Some symptoms persist out of habit. Once in an environment where normal behavior is the rule a patient may throw off his peculiarity, especially if discussion of it is not taboo. Sometimes symptoms persist but the patient adjusts to them. Hallucinations do not bother anybody if the patient can learn to keep them to himself—and many can.

However, sympathy and tolerance should be laced with common sense. Whatever the reason for the patient's behavior, he needs to learn to live in the world as it is—without being conspicuously a patient and without painful embarrassment or injury to himself or others. Two patients I know have the same delusion; each is convinced she is soon to be married. One

regales the ladies in her boarding house with tales of her fiance, while waiting for him on the porch each day. When he fails to appear, she looks forward cheerfully to the next day. All right. But the other patient becomes gradually so passionately convinced that her marriage will occur immediately that she orders a trousseau from a city department store. That is out of bounds.

If the hospital will give you some idea of the patient's pattern when he becomes ill, you and the careholder can be alert for premonitory symptoms without scanning every reaction anxiously. Sometimes a stitch in time, through one of the psychiatric drugs, may head off relapse. Sometimes the patient is better back at the hospital, if only temporarily. Many succeed but even those who fail can use the experience profitably for another attempt in the future.

Illness is part of the whole person but only part; its significance, in terms of foster care, is the practical question of how much it interferes with getting along. But, in this sense, so may many other personal

characteristics interfere that are not necessarily "symptoms."

I am not suggesting that no further understanding of mental illness is desirable, only that you need not be fearful of using your good common sense, with the same sensitivity and courtesy you offer any client, because of what you do not yet know.

Patients are not invalids without inner resources. Many respond to challenge with surprising ability. One old man, who seemed to need a lot of care and tactful handling because he was so cantankerous and seemed so little able to do for himself, rose to the occasion when his careholder became ill. He took care of her without a grumble. At last *he* was needed!

Mental patients are not needed; people are. Mental patients cannot succeed in this world as mental patients—they can as people. The worth of foster care—whether in Gheel, Maryland or Minnesota—lies in the opportunity it offers to mental patients to find themselves once more as human beings, contributing to others as well as receiving from them.

MABEL B. PALMER, M.S.W.
E. LEE HOFFMAN, Ph.D.

A study of the membership and program of a club for expatients of mental hospitals

"Will this new member find the social club for expatients helpful?"

Every director of social clubs for expatients of mental hospitals ponders this question as he greets each newcomer. Will the new member come once and never return? Will he come now and then, but never seem to profit from the experience? What are the characteristics of the person who can benefit from such a club?

By means of a study just completed, the Louisiana Association for Mental Health attempts to identify the candidate who can benefit from the expatient social club. According to the findings, if a person can meet four out of six of the qualifications given below, the chances are good that he will benefit.¹ Here are the qualifying questions:

1. Is the member in the age range 25-45?
2. Is he potentially employable?

3. Does he represent the white-collar, middle-class, socioeconomic group?
4. Does he have at least a twelfth grade education?
5. Has he been hospitalized less than six months, and on no more than two different occasions?
6. Is he currently receiving psychiatric help from some source—private, a clinic, or a social agency?

Finding the criteria of a good referral

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¹ This check list was determined by tabulations of the questionnaire responses from the 41 members of the sample who were considered the most successful.

was just one of the goals of the study by the Louisiana Association for Mental Health.

After five years of work with the social club, the Association no longer asked, "Do the expatients benefit?" but "*Who* benefits most?" The staff members no longer asked, "Is the program helpful?" but "*which* program is best for the expatient?" and "*how* do you judge success in an expatient club?"

Now that socialization had become an accepted part of the total rehabilitation program of the mentally ill, a greater refinement of goals was needed. We felt the need to sort out, as we had in other services working with the expatient, answers to such additional questions as:

What type of expatient benefits most from a social club experience?

How do we judge the success of a social club?

What program should a social club attempt?

This study was designed to begin to answer these questions and to set up criteria for work with social clubs for expatients.

THE STUDY

The Background

Five years ago when the Louisiana Association for Mental Health,² along with many other mental health associations, saw resocialization of mental patients as a specialized area of program in which it might be helpful, it, like many other groups interested in starting similar programs, found no precedent, no guidelines by which to plan. Therefore, its board called on a group of professionals, as volunteers, to

assist in setting up goals and criteria for membership in the club.

This group decided that the club would:

1. Accept referrals from the hospitals, private psychiatrists or social agencies;
2. Draw its membership from the 20-50 age group, or roughly the young adult group (both the adolescent and the older person would be excluded because they would require different programming);
3. Refer the alcoholic and psychopath to other agencies. The committee felt that they needed a different type of program.

Consequently, by virtue of the original plans, there was some selectivity in membership.

The Design

With this five-year background of work with the club, a careful study was needed for future planning. It was decided, first, to contact the 125 persons who had been members over the five-year history of the club. Of these:

- 71 were interviewed;
- 5 refused to be interviewed;
- 15 were known to have moved from the city;
- 2 were deceased;
- 32 could not be located.

Therefore, the 71 individual interviews conducted by a university counselor³ provided the data for this study.

Contacting the Members

A letter was first written to all members, explaining the purpose and plan of the study and introducing the interviewer who would be contacting them for an ap-

² *Annual Report of Magnolia Club, 1957, 1959, 1960.*

³ Samuel Jenny, M.A., student counselor at Louisiana State University in New Orleans.

pointment. The interview, held in the member's home, had both advantages and disadvantages. It was thought that if he were away from the Association's building, where club meetings were held, the member could be more objective. However, family members were sometimes present during the interview, thereby influencing some parts of it.

Validity of Sample

In order to determine whether or not the sample group was representative, a comparison of the 71 members contacted and the 54 not contacted was made. This comparison by sex, age, and the attendance record is shown in Table 1.

TABLE 1

Sex, age, and attendance comparisons of group contacted with group not contacted

		Per cent in group contacted	Per cent in group not contacted
Sex	Male	38	35
	Female	62	65
Age	20-29	28	54
	30-39	39	20
	40-49	23	26
	50+	10	0
Attendance	Rarely	44	45
	Frequently	34	17
	Regularly	22	38

Subjects of the Study

The 71 subjects ranged in age from 20 to 60; the median age was 35. Approximately 73 per cent of the group were between 25 and 45 years old.

Of the 71 subjects, 27 were male, giving 38 per cent males versus 62 per cent females. Sixty-two per cent of the subjects were

single; 18 per cent were married; 8 per cent were separated; 10 per cent were divorced; 2 per cent were widowed.

Of the subjects, 62 per cent were living with their parents or spouse and 23 per cent were living alone. The remainder were living in boarding houses or with friends in some other arrangement. Only 8 per cent of the subjects felt that their present living arrangements were not satisfactory.

Of the 71 members interviewed, 7 attended only one club meeting. An additional 14 attended from two to five meetings. These 21 cases, it was predicted, would be at one extreme or the other on the rating scale pertaining to degree of wellness.

Table 2 presents the distribution of ratings for these 21 cases and for the remaining 50 who attended six or more meetings. A chi-square test supports the conclusion that these two variables of classification are not independent.

A comparison of the two groups showed that there was a greater percentage of cases from the group attending five or fewer times that were rated in the extremes. They were either (a) likely to need to return to the hospital, or (b) sufficiently well to be able to adjust to a job, to family and social life. The group that experienced substantial contact with the Magnolia Club consists largely of individuals who were judged to be making a marginal adjustment, with community support and medical help.

FINDINGS OF THE STUDY

With the initial questions in mind, the researchers studied the findings of the project. They were able, in most instances, to compare the successful group of members (as judged by themselves, the club director and the interviewer) with those

TABLE 2

Comparison of club attendance by degree of wellness

	Attended 5 or fewer times	Attended 6 or more times	
Will likely need to return to hospital	9	10	19
Will be able to remain out of hospital but make a limited adjustment	7	32	39
Will be able to adjust to job, living and social life.	5	8	13
	21	50	71
			$\chi^2+5.91, p<.06$

who were judged not to have profited so much.

1. What Type of Expatient Benefits Most From a Social Club?

Age. Although in the original qualifications of membership there was some selectivity in the referrals to the club (as the club was set up, the membership would be in the 20-50 age group), more refinement was needed. Was it significant that many of the younger members dropped out?

As Figure 1 points out, the bulk of the successful membership fell within the 25-

45 age group. Although it was true that within the total membership, fewer of the members came from the under-25 or over-45 age groups, it must also be pointed out that proportionately fewer of the successful members came from each of these two extremes.

The members who were considered to be more successful who attended the club meetings more regularly tended to be more homogenous in age than in the total group. The age distributions for the total group and for this subgroup are presented in Figure 1. The dashed lines in the figure

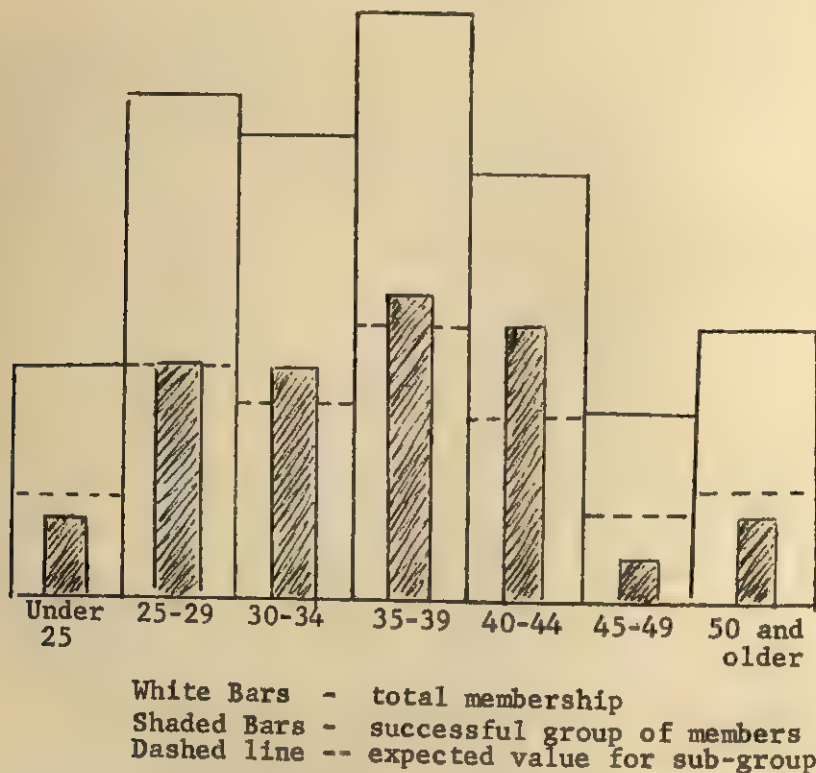
indicate the expected value for the subgroup under the hypothesis of no difference in age distributions.

While no rigid line of demarcation was held as a limit, the very young and the very old member dropped out, leaving a

same social needs, a closer look at the membership had borne out the principle that the fulfillment of social needs is based on homogenous groupings according to age, interest and skill.

While this study does not negate a need

FIGURE 1
Age of Club Members



more homogenous grouping. It soon became clear that the expatiant in his early twenties, like all others in his age group, had different social interests and skills from his older friends. Whereas they might have had social needs that were the same, the younger group demanded a different type of programming. The same problem was true for the adult over 45 whose interests and skills reflect his experience. Whereas many expatients had the

to work with the individuals within the youngest and oldest age groups, it pointed out that more members benefited if the majority of them were in a homogenous age grouping. The study indicated that the age group (within this community) who most needed and could most effectively use the social club was the 24-45 age group.

Employment. The interview questions regarding the employment history of the subjects revealed that only 29 per cent of

them were working at the time of the interview. However, of the 71 per cent who were not working at the time of the interview, 45 per cent indicated that they planned to work soon. In general, the members planned to return to the same type of job they had before their illness.

When asked to indicate the best job they had ever had, 44 per cent of the total sample responded with a job that was classifiable as a white-collar occupation. Of the remaining group, one had been a teacher, one a registered nurse, four had never worked; the remainder had, at best, occupied jobs in the laboring class.

On closer look, a majority of the successful group had formerly held jobs within the white collar class, whereas in the less successful group, a majority had either never worked or had held laboring class jobs.

In further comparison, 45 per cent of the successful group were working, whereas only 6 per cent of the unsuccessful group were working.

Thus we can conclude that the person who is working, or who will be planning to return to work soon, is more likely to be a good candidate for an expatient club.

Education. Granted that the education of the members is an important aspect in the homogeneity of the group, does this too play an important role in the member's ability to use this resource successfully?

The education of the subjects ranged from fourth grade through college. Fifty-eight per cent of the members studied had completed high school and 24 per cent had attended college. Eight members had attended business schools and five, trade schools.

By comparison, in the successful group, 73 per cent had completed high school and

30 per cent had gone on to college. One might speculate as to whether additional education indicated more experience with groups, thereby making the club a more familiar setting.

Current psychiatric treatment. Since the majority of the members are referred, a high percentage of members are currently receiving psychiatric treatment from private or public sources.

At the time of the interview, 72 per cent of the group were still receiving psychiatric treatment. Fifty-three per cent were receiving help from the local aftercare center; 13 per cent attended an outpatient clinic; 24 per cent were treated by private psychiatrists, and the remaining 10 per cent relied on some other source for psychiatric assistance.

Of the group classified as successful, 70 per cent were still receiving treatment, compared with 74 per cent of the unsuccessful group, who were receiving help.

Length of hospitalization. Turning to the hospital background for the group in this study, we found a range in length of hospitalization from less than two weeks to more than seven years. However, two-thirds of the group had spent less than a year in the hospital, and one-half had spent less than six months in the hospital. Two-thirds of the group had been hospitalized previously from one to ten times, with a median number of previous hospitalizations of approximately two.

II. What Is Success in the Social Club?

More than likely, different criteria of judging success have been used in every social club. When the Magnolia Club was begun, the goal was for the patient to be a member of the club for a relatively short period of time, and then to move on to an

already existing group within the community. The club was considered a short-term step from the hospital into the community. Here is an example.

Jim, a new member, fulfilled this criterion for membership. The staff of the aftercare clinic referring Jim to the club indicated that he needed to gain more confidence in social situations and to make friends. He stayed in the club only a few months, until he learned to bowl. He soon joined a bowling group and became interested in the various activities of a league. After a short time with his new and avid interest in bowling, he had no "time" for the club; thus the club had been successful for Jim.

Before long, however, it became clear that, while short-term membership may be the goal for many patients, for some this is not possible. The latter may require a longer term in the club. Even then, they may not join other organizations, but this does not mean that they do not socialize. Not everybody is a "joiner."

Some members, less social in nature, may not join other organized groups, but they may learn to develop their own social life with friends. This was true with Joe, who joined the club as a very fearful, shy member, lacking both confidence and social skills. However, he was a handsome young man. He used the club as a testing ground for learning to make new friends and to learn new social skills. He soon found himself becoming interested in being with people. By the time he returned to school to complete his college work, he no longer needed the club. Nor would it have been desirable for him to continue coming. Joe might not have joined other organizations, but he was now more comfortable in making his own social life.

For Anne the problem was different. The 20 years she had spent in the state

hospital had left their mark. The goal with Anne was to help her stay out of the hospital. In order to do this she would need to be helped to live a bit more independently so that she would be able to move around the community and to function within her family unit more freely.

Jim, Joe and Anne needed the club, but for very different reasons. The same criteria of success could not be set up for all of them. Therefore, in deciding who had been helped by the club, a subjective evaluation had to be made according to the member's need and the goals set for him.

III. What Program Should a Social Club Attempt?

The first and possibly the most important standard for the club is socialization. This is the place where the members would like to relearn how to make friends, to take part in social activities, to enjoy the companionship of people of similar interests.

They do not come to the club to learn how to handle their psychiatric problems; most of the members have indicated that they go to a private psychiatrist or a clinic for this purpose. They come to the club for social activity.

More than 73 per cent of the members in the study felt that the club had been helpful to them following their hospitalization. When further questioned as to how it had helped, 24 per cent indicated that it had helped them gain confidence in themselves. Forty-nine per cent felt that it had helped them make friends more easily. Another 69 per cent felt it had provided them with a source of activities at a helpful time.

In comparison, the same expatients said that the two major problems they faced following hospitalization were in gaining

confidence in themselves and in making friends.

This seems a clear indication that the program must test itself against these objectives:

1. Does the club program help the member gain confidence in himself?

The expatient club member needs a program of activities in which he can be successful without too much practice. More than likely, he has not succeeded at too many things in his past experience, so he needs to know that he *can* win at something. Thus he will learn through the activities that he is worth something!

2. Does the program give him the opportunity to make friends?

In a comfortable climate, the shy, unsure expatient may need to test out his ability to make friends. Or, as one member expressed it, "he may need to learn again to carry on a conversation." In an atmosphere where he does not need to hide the fact that he has been in a hospital (because all members have) he can feel more sure of himself in meeting strangers.

3. Does the club give him the opportunity to learn new social skills?

Many of the members need the chance to learn skills which will help them to move into social groups. To be able to learn a new card game, to master a new dance step, to bowl, to become adept at outdoor cooking may be new experiences for many persons. All of these skills will give the member new avenues in which to move.

The club must give an atmosphere of freedom and acceptance that will enable the shy, unsure member to try a new activity and encourage him to increase his skills.

4. Does the club give him the chance to become familiar with the social resources in the community?

Many persons may not be aware of all of the resources for social activity open to him within the community. For how many is their knowledge of socialization limited to a movie or some other spectator activity? The club has a responsibility to introduce the member to the wealth of local resources, both organized and unorganized. For some members this may be becoming familiar with a local chess club in which he may participate; for others, a bowling league, concerts and plays, a church choir, or adult education opportunities.

If the club can help the member find a new outlet for his interest within the community, it has fulfilled one of its goals for him.

This study points out that not every person needs or is able to benefit from an experience in the more structured expatient club. For the group work-oriented program, the more homogenous group is most effective. Working within a framework of group goals, the worker must be keenly aware of individual needs, skills and interests in enabling the member to make the greatest use of the experience. Only as the person is able to move toward these individualized goals and as the club becomes a true bridge, does it become an effective tool aiding his re-entry into the community.

Natural family pointers to foster care outcome

The child who is forced by circumstances to remain in temporary foster homes for a long period of time, unable either to obtain legal adoption or to return to a stable natural family, is a familiar and often distressing figure to social workers.

Such children usually carry special handicaps in the way of family or societal rejection, and too frequently they grow up socially or emotionally disturbed, a fact of considerable concern to the agencies feeling responsible for the child's future.

Recently there has been a call for increased efforts toward legal adoption (1), but it is by no means certain that this is the universal solution, and the problem is likely to be with us for many years.

The system of foster boarding homes is not necessarily at fault, if properly used, since it affords a means of selecting familial milieux to match specific needs; and many children grow up thus, apparently normal.

What is needed, however, are better means of matching child to foster family, and some way of identifying the vulnerable children from those who seem to be able to develop sturdily, almost irrespective of their milieu.

As a first step toward meeting these needs, an exploratory series of studies was initiated in Montreal in 1961. Ideally, a prospective approach was called for, but in view of the high cost of such an attack and its not infrequent failure to produce results commensurate with the effort involved, it was decided first to work retrospectively, using existing local records.

These records, compiled by many hands and in various stages of completeness, comprised the total foster placement files of one joint agency from 1928 to the present, and apparently provided unsuitable material for research. However, a trial run showed that nearly all of these records could yield certain minimum data, and the situation was enormously improved by the presence in the agency of two senior officers who had

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been with it nearly the whole time and who proved to know something of the after-history of nearly every long-term foster child. Cases were therefore selected which showed:

- A. More than five years continuous foster boarding care;
- B. Closure by the time our study began;
- C. The child reaching the age of at least 11 prior to closure; and
- D. No indication of mental subnormality (confirmed I.Q. of less than 85), or of brain damage.

For each child thus identified, three categories of information were sought; namely, an estimate of outcome in terms of mental health in late adolescence or early adult life; uniformly codable data on the natural family at the time of first placement; and uniformly codable data on foster home history. In all, 353 cases were studied, but 37 either could not be rated or in some way violated the selection criteria, leaving 316 for analysis.

The present paper reports such relationships between outcome and natural family background as might enable an agency to select the children most in need of special supervision and placement. A further paper on foster home variables will be forthcoming, and a clinical exploration of the associations described is planned for the near future.

THE ASSESSMENT OF OUTCOME

In view of the tentative nature of the research and the unknown reliability of the case records, it was decided that a subjective assessment of outcome at time of the last significant news of the subject was adequate for present purposes. It would not have been adequate if the judgments had been made by a multiplicity of case workers, or derived from case files, and it

would not have been possible if the agency had not possessed the two aforesaid officers with their long service and longer memories.

By using these as joint assessors, acting together and reaching a joint decision on the rating for each child, however, this method of judging outcome became both possible and, in the view of the writer, adequate to the level of accuracy which the research attempted.

The assessors were given a list of the children's names and case numbers. They were asked *not* to refer to the case files, and only to refer to other records for the purpose of distinguishing two children with similar names. A third supervisor was brought in to supply post-closure information on a few children that the others had not followed up, and there were some children (fewer than 5 per cent) who could not be rated since neither assessor had sufficient knowledge of them. Rating was initially on a seven-point scale, but this called for a finer separation of judgments than knowledge of the children's subsequent career seemed to justify, and the seven were reduced to the following three fairly clear categories:

- A. Outcome satisfactory in terms of the child's social milieu;
- B. Outcome less satisfactory than A, but without signs of pathology or open disturbance;
- C. Outcome unsatisfactory, usually with signs of pathology or disturbance.

The information on which the foregoing assessments were made came from three main sources: the subjects themselves, their former foster parents, and interagency, court and hospital contacts. If children remained in foster homes until they became independent, it was usual for them to retain contact for some years either with the

agency itself or with a foster mother, and one or the other would then be seen two or three times a year until the tie was finally broken.

If they transferred to an agency residence or boys' home prior to becoming independent, direct contact would be less frequent, but the heads of the various agencies and homes met at least once a year to exchange information on such earlier transfers. If the children appeared in court or were admitted to a psychiatric clinic or hospital within the Montreal area, the assessors could usually rely on receiving news, since an inquiry would be sent by the court or hospital social service regarding details of earlier life. Only if the children had returned to their natural parents at a relatively early age, and if there were no subsequent disturbances in the family, was contact likely to be lost early or maintained only at third-hand. But in this group of long-stay foster children the last event was rare.

The age to which contact is retained proves to be somewhere in the early twenties, on the average. However, not all subjects had reached that age by the time of the present study, and the mean age to which outcome ratings apply is 20-21.

Unsatisfactory, i.e., "C," ratings prove on rechecking to have been given to all subjects who had admission to a mental hospital or involvement with the courts in adult life, unless for a trivial charge. In addition, a poor work history, combined with evidence either of sexual deviancy or history of psychiatric treatment after closure of the case, usually was rated "C." Sexual deviancy, a poor work history, or outpatient psychiatric treatment by itself, however, might not get rated "C" if there were evidence suggesting that this referred to a transitional phase and that the subsequent career was more stable.

Satisfactory, i.e., "A," ratings prove on rechecking to have been given if there were a steady work history up to time of being lost from view, if nothing adverse was known about the case, and if there had been no manifest disturbance in childhood. Where there had been a manifest disturbance in later childhood or adolescence, however, the assessors showed themselves reluctant to give an "A" rating unless positive evidence of later adjustment was available. "B" ratings were given in those cases where it was felt that the evidence was inconclusive, plus those where the assessors knew of later personal difficulties but knew also that the subject had managed to keep them under control.

An attempt was later made to divide the "C" group into a delinquent and a neurotic and psychotic category, but most subjects showed both types of characteristics and this was not pursued. Apparently, the "pure" sociopath rarely arises from the type of setting being studied here.

NATURE OF SAMPLE

While various background characteristics of the children studied will appear as their relevance to outcome is reached, a general statement here may assist the reader to compare the Montreal sample with more familiar loads.

Because of the special character of social work organization in Montreal, all the children were nominally Protestant and English-speaking. While predominantly white, they included a higher proportion of mixed Negro ancestry than would be expected from the small number of Negroes in the Montreal population, since such colored children are still difficult to place for legal adoption. Almost none came from middle-class backgrounds and none at all from divorced parents, the reason for this being that legal divorce is not

available to the poor in Quebec Province. Formal separation and informal desertion were common, however.

Boys considerably exceeded girls in the sample, although approximately equal numbers could have been expected. This excess proves to come from families broken by means other than death of a parent (see Table 1), but the reasons for it are not yet known. Regarding age at first placement with the agency, there is a fairly even distribution from infancy to eleven (see Table 6), but boys tend to be placed slightly younger than girls (mean ages 5 and 7 respectively). A fifth of the children were illegitimate, and less than a fifth came from one-child families.

Reasons for placement with the agency are not easy to tabulate, since intake workers tended to be less interested in the reason given by the parent or relative than in the grounds which they themselves perceived in the family situation. However, illegitimacy per se seemed relevant in only 7 per cent, mental disorder of a parent in only 6 per cent, and other illness as the principal reason in only 12 per cent. The intervention of the Montreal family court or its predecessor was of minor importance, since most cases reached the agency directly or through referral from some other organization.

EMPIRICAL INDICATORS OF OUTCOME

The purpose of this research was two-fold: to assist the agency in spotting those children in greatest danger of later mental disturbance, and to detect the factors underlying such danger. It was felt that any significant means of identifying at an earlier stage the children most likely to achieve a poor adult outcome was worth finding, even if the association could not be explained. The agency could then,

hopefully, begin to separate the high risk from the lower risk in their present caseload, and give the former special supervision.

However, until the mechanisms underlying the association with outcome were understood, it was always possible that past findings would not apply to the present, and quite probable that Montreal findings would not apply to other settings. A further search for underlying factors is thus imperative.

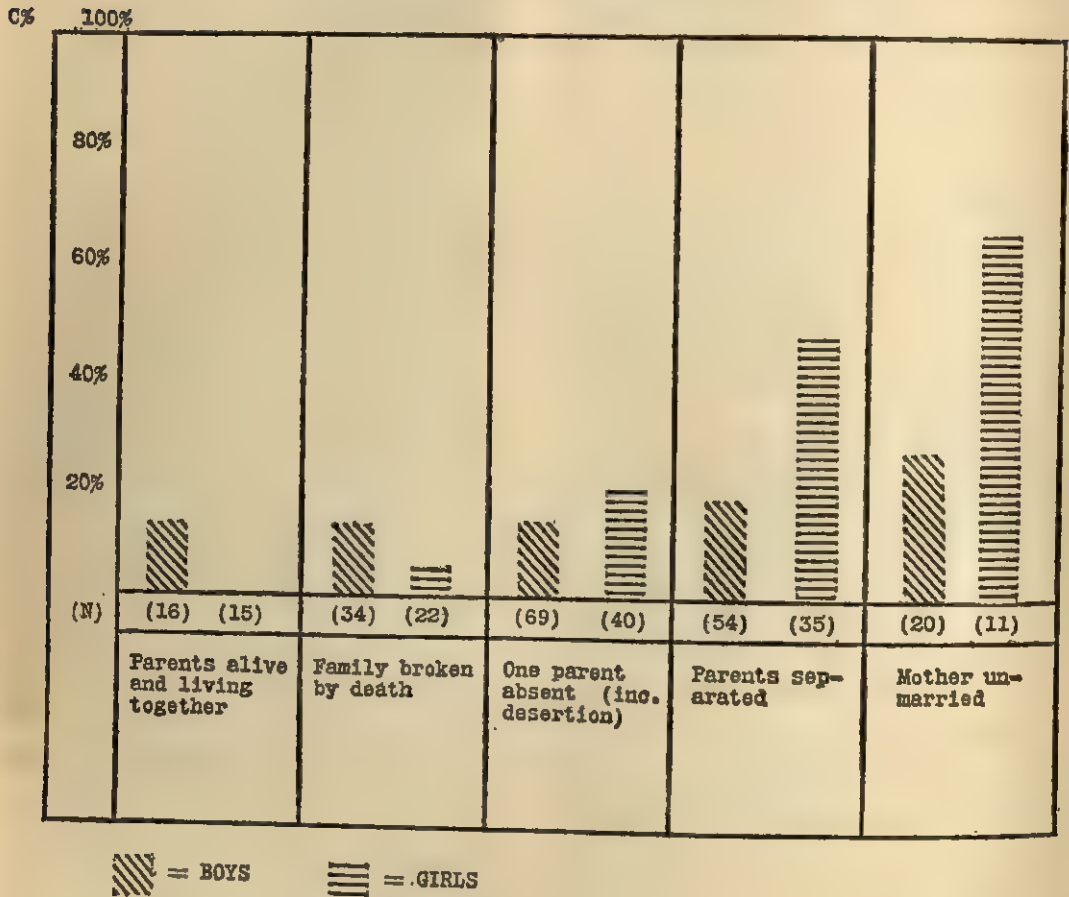
In the present paper the empirical associations will be presented with the warning that they must not be assumed to apply in other settings. Elsewhere, a discussion of possible factors will be offered, but a real understanding of them must wait for further research. The empirical findings are striking and, in the main, relate to the early stages of placement, when the agency should have the most power to act.

Each indicator has been reviewed in light of the possibility that the assessors might have taken it into consideration in making their ratings (so that the ratings would not be independent). It has been concluded that while the "A" ratings might sometimes have been affected in this way, the "C" ratings, with their reliance on manifest late pathology, should not have been. Associations with outcome will therefore mainly be presented in the form of percentages of unsatisfactory ("C") outcomes.

As will soon be seen, indicators operate differently on the two sexes. Within this limitation, they will be presented in order of their importance for the present task rather than in the order they would appear in the normal social history. Naturally, only matters routinely referred to in the studied records can be discussed; there may be other much stronger indicators that are untapped at present.

FIGURE I

Percentage of unsatisfactory outcomes as related to family structure at time of placement, by sex



Family structure

As Figure I and Table 1 show, family structure at time of placement is, by itself, an extraordinarily accurate pointer to outcome for the girls of the present sample. As one progresses from the unbroken family, through the family broken by death, to the family that has been given up by its partners (separation) or has never truly existed, the percentage of girls with unsatisfactory outcomes rises from nil to 64 per cent.

Moreover, over two-thirds of all girls to whom an unsatisfactory ("C") rating was given come from separated or unmarried parents, whereas only one girl out of the 37 coming from families that were unbroken or broken only by death received that "C" rating. Thus, with this one indicator alone, a considerable triage can be achieved.

Yet the finding is as curious as it was unexpected. All these girls had experienced a minimum of five years in foster homes;

the family structure at time of placement was not something that necessarily had existed for long or would persist for long; and in many instances there was virtually no contact between child and natural parents after placement.

Also, family structure, while a conveniently objective dimension for the present study, does not seem particularly close to the underlying interpersonal factors one would expect chiefly to affect a child's development.

And, finally, there is the surprising fact that among boys the same association is so weak that it could theoretically have arisen by chance. The mode of rating has been checked to see whether the assessors could have been taking the early family structure into consideration, but this seems highly unlikely. Therefore, the strength of the association must remain unexplained for the present.

Parental pathology

Three indicators of what can broadly

be called parental pathology were used in the present coding: drinking pattern, frank mental disorder, and existence of a criminal record suggestive of mental disturbance. Each parent was coded separately in terms of what was recorded by the intake worker, and coders were granted considerable latitude in the ratings given.

When taken individually, none of these variables proved to be associated with poor outcome in enough instances for them to be of much use as predictors. When combined, however, a classification of some predictive value for boys appeared, and this proved to vary independently of family structure. Thus, considerable separation of poor from good outcome cases could be achieved by a combination of the two variables.

Table 2 presents the picture. In it, "simple pathology" means the presence of either heavy drinking, frank mental disorder, or criminality suggestive of mental disorder in one parent; "multiple pathology" means the presence of heavy drinking plus mental disorder in the same parent, or of pathology

TABLE 1
Formal family structure at time of placement, as related to percentage of unsatisfactory outcome, by sex

	Boys		Girls	
	N.	C%	N.	C%
1. Parents alive and living together	16	12%	15	0%
2. Family broken by death;	34	12%	22	5%
a. Father dead, mother not remarried	6	0%	7	0%
b. " " " remarried	1	0%	1	0%
c. Mother dead, father not remarried	18	17%	6	0%
d. " " " remarried	6	17%	4	25%
e. Both parents dead	3	0%	4	0%
3. One parent absent (incl. desertion) *	69	13%	40	20%
4. Parents separated *	54	17%	35	46%
5. Mother unmarried	20	25%	11	64%
TOTAL SAMPLE	193	15%	123	26%

* See postscript.

TABLE 2

Relationship of foster child outcome to presence of mental pathology in natural parents at time of placement, by sex of child and by structure of natural family

Parental Pathology	Family Structure					
	Parents separated ^a or mother unmarried		One ^b parent absent		United, or broken by death ^c	
<i>Boys</i>	(N)	C%	(N)	C%	(N)	C%
1. Multiple pathology	(15)	47%	(9)	33%	(4)	—
2. Simple pathology	(22)	27%	(25)	8%	(21)	5%
3. No pathology reported	(37)	3%	(35)	11%	(25)	20%
Chi ² =16.5; n=2; p=0.001, combined						N.S.
<i>Girls</i>	(N)	C%	(N)	C%	(N)	C%
1. Multiple pathology	(15)	67%	(8)	25%	—	—
2. Simple pathology	(8)	25%	(11)	36%	(15)	0%
3. No pathology reported	(23)	33%	(21)	10%	(22)	5%
Chi ² =5.86; n=2; p=0.07, combined						N.S.

Family structure categories: a) categories 4 and 5 in Table 1;

b) category 3 in Table 1;

c) categories 1 and 2 in Table 1.

Parental pathology categories—see text. Chi² tests were made after combining family structure categories in order to obtain larger numbers in each cell.

in both. A more uniform recording of intake data would have provided a more logical classification and probably higher correlations with outcome, but this division is what proved to be most practical with the information given.

As can be seen, in both boys and girls the presence of multiple pathology increases the likelihood of a poor outcome when the mother is unmarried, the parents separated, or when one parent is living but absent. In boys, the separation is very marked and fully significant; in girls, it is less marked, with family structure, for them, remaining much more relevant than family pathology.

A curious point can be seen, however, in the boys' group. Where the family structure is relatively normal, with the parents living together or with one parent dead, the association between parental pathology

and outcome disappears, or even seems to move in the reverse direction. Similarly, where no pathology is reported, outcome is apparently better in the more disturbed families than in the supposedly least disturbed.

The reverse trends are not significant and possibly accidental, but the absence of the customary trend suggests that relative family normality in one direction may compensate for abnormality in another. Expressed in another way, it might be inferred that outcome depends on the amount of normal social intercourse and guidance that a child receives, rather than on the character or intensity of the abnormality to which he is exposed.

This last point can be illustrated in two ways. In the first place, there were only five children whose parents exhibited more than two items of mental pathology, as

rated here. (Usually this meant mental disorder and heavy drinking in one parent, and heavy drinking in the other.) All five received a "C" rating.

On the other hand, there was a total of seven boys placed with the agency because their mother became mentally ill, but also coming from families that had hitherto been unbroken or broken only by death. These seven boys all received "A" ratings. As the last point illustrates, therefore, mental disorder in a parent is not in itself an indicator of poor outcome.

Financial maintenance

Where an agency encourages parents to contribute something toward the costs of foster care, the response, although theoretically determined mainly by income and material ability to pay, is likely to reflect to a considerable degree the parent's interest in and acceptance of the child. Where such contributions are routinely demanded and routinely recorded, therefore, one may possess a relatively objective and easily ascertained measure of persisting parental attitude, and this, in turn, may be relevant to outcome.

For the present analysis, the payment or nonpayment of contributions was recorded, and the former was classified, not by amount paid, which varied too much over the years, but by the regularity with which it was paid. Of course, irregularity or nonpayment of contributions may be affected by matters other than the parent's attitudes, but alternative reasons such as irregularity of employment also reflect something of the parental character, and hence are of some relevance.

Taken by itself, this variable shows only a moderate relationship with outcome. Taken along with the variables previously discussed, however, it proves to be of considerable relevance.

Figure II depicts the effect. One sees that when the family structure is unfavorable and when parental pathology is present, there is still a considerable difference in outcome between those children who received regular financial support from a parent, and those who received no financial support at all. For girls coming from more favorable families, and for boys in whose cases no parental pathology was reported, however, the payment or nonpayment of contributions has no significant association with outcome.

With girls, in other words, financial maintenance is a better contributor toward predicting outcome than is parental pathology, and it can therefore be substituted for it. With boys, however, financial maintenance only helps to discriminate outcomes when parental pathology is present, and thus cannot be a substitute for the latter.

Financial maintenance behavior is not something which can be measured at the intake interview and therefore cannot, strictly speaking, be used as a means of immediately separating high-risk from low-risk cases. It would appear to be a useful point to keep under review, however, and in many cases assessment can be made quite early.¹

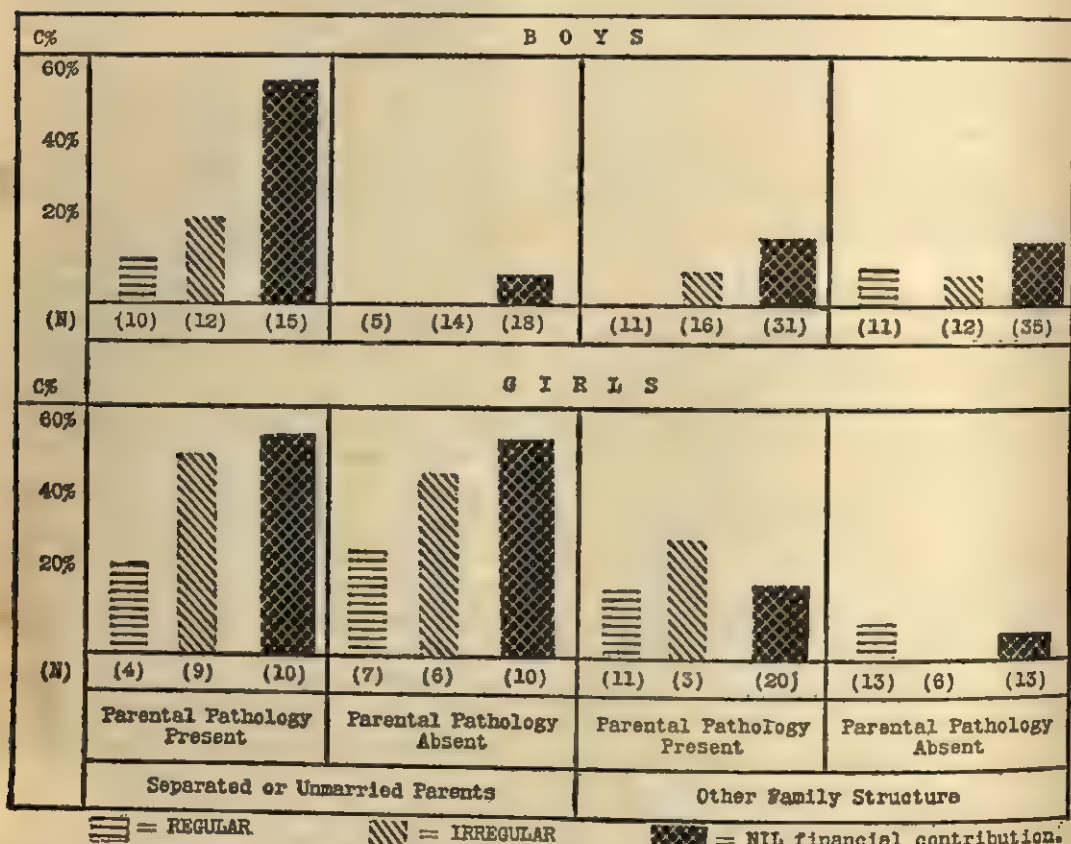
Parental visiting

One of the few pointers to outcome that can be found in the earlier literature relates to parental visiting. Susan Isaac (3), and Stout (2), and, more recently, Weinstein (4) have all produced evidence suggesting that foster children are healthier

¹ In Montreal, unfortunately, control of financial contributions by natural parents has recently been taken out of the hands of the agency, and therefore it is no longer easy for the local caseworkers to follow this suggestion.

FIGURE II

Percentage of unsatisfactory outcome as related to character of parents' financial contribution, by sex, two categories of family structure and presence or absence of parental pathology



≡ = REGULAR ≡ = IRREGULAR ≡ = NIL financial contribution.
 Children with both parents dead at time of placement have been omitted from this comparison.

when they receive visits from their natural parents than when they do not. It thus has seemed reasonable to extrapolate this with respect to outcome, and perhaps even to infer that visiting should be encouraged when it does not occur spontaneously.

With respect to the present study, it might also seem reasonable to suspect that the foregoing association between outcome and financial support might be secondary to a more basic association between out-

come and visiting, on the assumption that the parent who does not visit is likely to be the one who does not pay.

The relationship which the data reveal, however, is much more complicated. In the first place, as Table 3 shows, there is a marked difference in outcome between those children having frequent contact with their natural parents and those having slight contact, and the outcome of the former is, on the average, poorer than that

of the children with no contact at all, once family structure is allowed for.

In the second place, the relationship between visiting and financial support is not as close as one might expect. It is true that parents who have no physical contact with their children tend not to pay financial contributions, but many who pay nothing do have regular contact. Yet a third complication is the fact that contacts can be of different kinds and can change with time, and the different types appear to have different relations to outcome.

For the present analysis, six categories of parent-child contact were coded: visits in the early foster years by mother to child, visits by father in same period, visits by mother in later foster years, visits by father later, and visits by child to each parent. For Table 3 the picture for the early years was taken as being of more relevance to the prediction of outcome, and the direction of visiting and parent contacted was ignored. Analysis of the latter points had

shown that they were of little relevance.

In Table 4, visits in later years are also taken into consideration, and changes in pattern of visiting estimated. Some changes have little relevance for this inquiry; for instance, a shift from mother visiting son to son visiting mother. Other shifts do have relevance, and the different patterns have apparently different significance for the two sexes.

With boys, frequent contact has a favorable significance, provided it is maintained; with girls the same frequent contact, whether maintained or not, has a poorer than average outcome. With boys, absence of visiting is generally of poor prognostic significance; with girls, the same is true only if both parents are locally available (at least at time of placement). Boys are apparently susceptible to a decline in contact (or to some factor underlying such decline); this is not true of girls.

To disentangle the numerous elements which contribute to the complicated rela-

TABLE 3

Relation of visiting patterns to foster child outcome, by family structure, payment of contributions to foster care, and by sex of child

		Boys				Girls			
Financial contributions.....		Nil		Some		Nil		Some	
Family structure	Visiting pattern	(N)	C%	(N)	C%	(N)	C%	(N)	C%
nmarried or separated*	Frequent	(6)	67%	(28)	11%	(5)	100%	(16)	44%
	Infrequent	(14)	7%	(12)	8%	(2)	(50%)	(9)	22%
	No visiting	(13)	38%	(1)	(0%)	(13)	46%	(—)	(0%)
Other categories	Frequent	(25)	9%	(25)	12%	(12)	17%	(19)	16%
	Infrequent	(22)	17%	(23)	0%	(22)	14%	(12)	8%
	No visiting	(22)	27%	(2)	(0%)	(10)	0%	(3)	(0%)

* Categories 4 and 5 in Table 1.

Visiting patterns refer to parent most often contacted, and to first two years of foster care only, both parent-child and child-parent visits being included. "Frequent" means an estimated rate of once in two months or oftener. "Infrequent" means less than once in two months, as estimated for visiting in one direction and with one parent only. In consequence, this category could include contacts more often than once every two months, if child were visited by each parent alternately and made visits to each alternately. "No visiting" includes contact by letter or by phone only.

TABLE 4

Relation of parental visiting patterns to foster child outcome, with allowances for changes in time

	Boys		Girls	
	(N)	C%	(N)	C%
Frequent visiting, maintained in time	(56)	7%	(45)	33%
Frequent visiting, declining with time	(33)	24%	(7)	28%
Infrequent visiting, increased with time	(17)	5%	(19)	22%
Infrequent visiting, maintained with time	(20)	5%	(13)	8%
Infrequent visiting, declining with time	(29)	10%	(13)	31%
No visiting; both parents available	(5)	60%	(7)	57%
No visiting; one parent available	(31)	26%	(15)	13%
No visiting; neither parent available	(2)	0%	(4)	0%

Changes with time refer to comparison between first two years and last two years of foster care, and take into consideration such shifts as child visiting parent in place of parent visiting child. Data refer to whichever parent is more frequently contacted. Availability of parents refers to time of placement only.

tionship between parental visiting and foster care outcome would need many more cases and a much more accurate inquiry than were possible here. What is of importance is that such visiting patterns are of much less value prognostically than the other variables that have been discussed. Also, it can be said on the basis of these findings that it is not necessarily wise to encourage visiting when it does not arise spontaneously; with boys there may be grounds for such action; with girls there are certainly none.

Parental rejection

In Table 4 it was shown that outcome was particularly poor in the few instances where both parents were apparently locally accessible, at least at time of placement, but had no recorded subsequent contact with the child. This lack of contact could have been due to death, hospitalization, imprisonment or to the parents feeling the child had the best chance in life by being left alone.

It could also mean, or be taken by the child to mean, absolute rejection, and it seemed desirable to check, as far as the material permitted, whether an attitude of rejection had the undesirable consequences that one would hypothesize in the child.

The hypothesis was only partly confirmed, being true for boys but not for girls. Coders had been asked to assess parental attitudes toward the placement in terms of a number of given categories, one of which was "happy to be rid of the child." None of the other categories proved to be at all relevant to outcome, but this one was, as Table 5 shows. The number of cases in which such an attitude was reported was small, probably smaller than it should have been; almost no mothers were reported to have this outlook, whereas some probably did.

Table 5 shows that where both parents are present and both reject, then outcome is poor. Apart from that, poorest outcome occurs where the father rejects his son and where there is no mother to counterbalance this attitude. It may be accidental, but these fathers are nearly all ones in whom no formal mental pathology (as previously measured here) was reported. Accordingly, for the present sample this question proves useful for predicting outcome in boys coming from homes that have not been indi-

TABLE 5

Foster care outcome in cases where parent expresses rejection of child at time of placement

<i>Assessed at time of placement to be "Happy to be rid of child"</i>	Boys				Girls			
	A	B	C	C%	A	B	C	C%
Both parents	2	3	3	37%	..	..	2	100%
Father only, mother not	3	5	..	0%	2	3	2	29%
Father only, mother is absent	6	1	6	47%	8	2	2	17%
Mother only, father is absent	1	1	..	..	1	1	..	..
Attitude reported	12	10	9	29%	11	6	6	26%
Attitude not reported	75	67	20	12%	53	21	26	26%

cated as high-risk ones by previous indicators.

In any event, since rejecting attitudes are more frequent than have been recorded here and since they can be ascertained at time of placement, they would seem to be worth looking for as potential indicators of trouble.

Birth rank and age at placement

From some current ideas on maternal separation it might have been expected that the age at time of foster placement would be quite relevant to outcome, with children moved in the theoretically most vulnerable years having a poorer outcome than those placed in the first few months or after the age of five. This does not prove to be true for the present material.

Possibly, age at placement did not sufficiently coincide with age at true separation; or perhaps the ideas on separation have inferred too much from the established findings on deprivation—a different concept. But in any event, as Table 6 indicates, age at placement is not by itself an aid to prognosis.

Taken in conjunction with other variables, however, it is of some relevance. For

girls, this relevance applies only to those *without* other adverse factors in their pre-placement history; for boys, it applies only to those in whose histories adverse factors are strongly present. For girls, it will be recalled that a high proportion of "C" ratings derived from natural mothers who were either unmarried or separated. Of the remaining "C"s, a further two-thirds can be isolated in the present material through a combination of birth rank and age at time of placement, as Table 7 shows.

With boys, the same association does not apply but what does appear is that when parental pathology is present and parents are unmarried or separated, the worst effects are to be anticipated if the child is between four and eight years old at time of placement (Table 8).

Since, in both these instances, one is dealing with quite small numbers, and since there is, in the case of boys, an overlap with other relevant variables such as multiple pathology in parents and absence of financial contributions, it is difficult to assess how much weight should be put on these two indicators for general application. In the present material, however, their association with outcome is quite significant.

TABLE 6

Case sample by age at time of placement, sex, and outcome rating

Age	Boys			Girls			Total	C%
	A	B	C	A	B	C		
0	9	5	5	10	..	3	32	25.0
1	3	5	..	1	..	2	11	5.5 ^a
2	10	7	..	4	3	3	27	11.1
3	7	6	3	4	3	3	26	23.0
4	7	4	6	3	1	5	26	42.3
5	14	13	1	6	1	3	38	10.5
6	4	10	3	5	2	3	29	27.6
7	9	6	..	7	7	2	31	6.4
8	6	5	6	7	3	4	31	32.2
9	6	8	1	3	4	2	24	12.5
10	10	4	2	8	2	2	28	14.3
11 and over	2	4	..	6	1	..	13	.. ^a
Total	87	77	29	64	27	32	316	19.3

^a The lower percentages of "C" at age 1 and 11 and over have been tested and found within chance variation by the Chi² test.

Forty-six of the children had been placed with the agency at an earlier age, returned to their parents, and then brought for long-term care at the age noted. Removal of these children alters the over-all picture which the table presents only with respect to lowering the mean age slightly; proportionate ratings are not significantly changed.

CONCLUSIONS

This paper has dealt with empirical associations between outcome and natural family history in a specific group of long-term foster children. Discussion of possible underlying factors and of the relation of these findings to other studies must await a further paper. It is clear, however, that

the associations do offer a possible means of separating the high-risk from medium or low-risk individuals in a similar foster child population.

What is the most convenient method of making use of these indicators?

One way would be to give weights to each of the anamnestic items cited, or al-

TABLE 7

Relation of birth rank and age at placement to outcome, for girls coming from married and not formally separated parents

Age at placement	Girls from parents not separated or unmarried					
	0-5		6 or over		Total	
	(N)	C%	(N)	C%	(N)	C%
Birth rank						
1st, 2nd	(14)	43% ^a	(31)	6%	(45)	18%
3rd and over	(18)	5%	(14)	0%	(32)	3%
Total	(32)	22%	(45)	4%	(77)	11%

^a Probability of this proportion occurring by chance is less than 0.001, by Fisher's exact method.

TABLE 8

Age at time of placement as related to outcome in boys with various family backgrounds

Family structure at time of placement.....Segregated or unmarried					Other family structure			
Parental pathology.....Present			Absent		Present		Absent	
Age at placement	(N)	C%	(N)	C%	(N)	C%	(N)	C%
0-3	(7)	43% ^a	(19)	5%	(18)	17%	(16)	17%
4-9	(20)	45%	(16)	6%	(27)	8%	(33)	15%
9 or more	(10)	10%	(2)	(0%)	(13)	8%	(12)	8%

^a Two "C" category boys placed soon after their birth by psychotic mothers probably suffered from inherited mental disorder, although the evidence in the records was not strong enough to justify exclusion. The high proportion of "C"s in the 0-3 group is therefore not considered significant for the search for social factors which this study represents.

ternatively to deduce hypothetical factors which, in turn, could be given weights. From such weights the probability of any particular child having a poor outcome, under standard circumstances, could be calculated. An easier approach to practical action, however, is to seek to place all children into either a high-risk or a low-risk category by some relatively simple rules of thumb.

With the present material, the most convenient rules were as follows, although slightly more efficient ones can be devised:

By this means, two-thirds of the total group can be put to one side as having relatively little risk, and the remaining one-third can be concentrated on in the knowledge that if uncorrected, almost half (47 per cent) are likely to turn out unsatisfactorily.

POSTSCRIPT

The experienced caseworker will recognize immediately that the simple terms "one parent absent" and "parents separated" hide a great variety of structural relation-

High-Risk Category

1. Mother unmarried or formally separated at time of placement; regular financial payments not being made; and, for boys only, parental pathology reported (51% C)
2. (From remainder)
 - a) Boys only; both parents, or sole remaining parent, express rejection (35% C);
 - b) Girls only; first- or second-born, and placed in foster care before age of six (44% C)

Low-Risk Category

All other children (7% C)

Yield

21% of total group;
52% of all C ratings;
12% of other ratings.

11% of total group;
21% of all C ratings;
8% of other ratings.

68% of total group;
27% of all C ratings;
80% of other ratings.

TABLE FOR POSTSCRIPT

	Boys		Girls	
	(N)	C%	(N)	C%
A. Separation largely by mutual consent:				
1. Casual separation with involvement in new liaisons; history of chronic instability of family structure	7	29%	7	57%
2. No legal steps initiated, but separation effected; both parents involved with child's placement	25	16%	14	50%
3. Legal steps initiated within six months of placement	26	16%	12	25%
	58	18%	33	42%
B. Separation largely by unilateral action or with one parent disappearing:				
4. Child remains mainly with mother	23	13%	17	41%
5. Child remains mainly with father	18	5%	10	20%
	41	10%	27	33%
C. Absence predominantly for other reasons:				
6. One parent chronically in hospital, prison, armed forces, etc.	14	14%	9	22%

ships, and are by no means as easy to distinguish as Table 1 would imply. In an effort to produce a better classification, a majority of the case records were re-read and various new classifications were attempted after the paper had been completed.

The following table presents the one which seemed most practicable and, at the same time, of most relevance for prognosis. It will be seen that the broad themes of the study are reconfirmed in this new analysis. Where both parents abandon the effort to maintain a united family, the prognosis is worse than if one makes an attempt to keep it going. Where separation is undertaken in a considered and serious fashion, with recourse to the law, the outcome is better than if it is done casually or impulsively, but still worse than if it is not done at all.

Where parental absence is due to factors at least partly outside the control of either parent, outcome is still the best (within the group restudied), even though this frequently involves mental hospitalization or prison.

The one new point to arise relates to the remaining parent when unilateral separation occurs (although not in other circumstances); contrary to expectations, outcome is clearly poorer in both sexes when the remaining parent is the mother than when it is the father.

Trial re-analyses of later parts of the paper using this new classification; e.g., Table 3, show that although different figures are naturally obtained, the trends and character of findings are the same. It has not seemed necessary, therefore, to change the original paper.

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CHARLES V. LAIR, Ph.D.
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Symbiosis of hospital and community: Opinions of residents, employees and volunteer workers

A mental hospital cannot remain indifferent and isolated from its environment; an interaction with the community must occur. However, recent investigations of attitudes of persons living within the vicinity have neglected the interpersonal exchange of knowledge and rumors that takes place between workers within the hospital and individuals of the community.

There has been a common assumption that society has negative attitudes toward mental hospitals, that people do see them as "dumping grounds" for misfits (1). All blame should not be aimed at those on the "outside," since there is good reason

to believe that persons on the "inside" have a few erroneous ideas of their own.

Therefore, an investigation purporting to evaluate those attitudes having adverse effects upon patient care must presume to analyze both inter- and intragroup opinions.

Actually, the large neuropsychiatric hospital has some responsibility in the initiation of educating the community, because a good emotional climate is vital to the rehabilitation of its patients. Before such action, though, a survey of beliefs is necessary to uncover areas of misinformation and ignorance as well as areas of relative sophistication about mental illness. A few informed reports in the professional literature suggest that maybe community attitudes are not as bad as might be thought. For example, Pratt *et al.* (3), have found in a community of 3,000 adults, where a

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1,500 bed mental hospital is located, that there are generally favorable attitudes toward the institution. It was found also that younger persons, professional workers and non-property owners were the most positive.

Sommer and Dewar (4) have surveyed a Canadian town of 8,000 (Weyburn, Saskatchewan) where a hospital of 1,500 beds is located. Once again, it was discovered that the community did not have particularly hostile attitudes toward mental illness or toward the institution. More of the Weyburn study will be reported later in this paper.

Finally, employees have not escaped investigation entirely. The findings of Hicks and Spaner (2) have revealed that positive attitudes can be developed among employees through education. What can be done for employees can be accomplished with others.

When the decision to make a survey of community opinions regarding the 1,500 bed Veterans Administration Neuropsychiatric Hospital of Knoxville, Iowa, was crystallized, a conference between key hospital personnel together with the mayor and other responsible citizens of the city was held. The representatives of the city seemed as interested in clarifying certain ideas as were those from the hospital.

All of the persons involved recognized false ideas harbored by townspeople and employees as well. An example of a widely believed but entirely unfounded opinion involved a whistle which sounds periodically at the hospital. Although the whistle is used only to signal fires, fire drills and disasters, quite a large number of local citizens thought it was a warning that a patient had escaped. From what the writers have been able to discover, such was the case many years ago. It reflects on the attitudes of the town, or perhaps on the

failure of the publicity of the hospital, that the idea is still so prevalent.

The goal of this study was primarily local in attempting to uncover information that would lead to better understanding with the town through more intelligently written publicity, more appropriate educational goals within the community, and in offering facts to city officials to assist in their aims of developing the town into a better and more provident place to live; however, there are broader implications behind the problems investigated.

Any single large institution dominating a town has obligations to its community. Conflicts of interest and values are certain to arise, and an intensive survey is the only way in which these are going to be revealed so that remedial action can be taken. Where the institutions are mental hospitals, there are probably problems of a general nature, as well as those peculiar to the local situation.

To get at broader questions, a measuring device used in a similar study elsewhere formed a basis for comparison in a more or less cross-cultural sense. So far as the interchange of attitudes is concerned within the community and hospital, it is well-known that an image is projected toward which others react.

The hospital, the residents of the community, the employees and the volunteer workers are each, in a generic sense, projecting an image of their own prototype through the way they perceive and through the way they react. A collection of opinions about all of these from each individual group should provide at least a starting place for the assessment of both positive and negative attitudes in relation to the whole.

PROCEDURE

A three-part questionnaire was prepared

and was ultimately evaluated, item by item, by the research committee of the Knoxville VA Hospital preceding collection of interviews. The first part of the questionnaire consisted of 20 items that could be answered "true," "false" or "don't know." Seventeen of the items were from a device used by Sommer and Dewar (4) in their study of Weyburn. The similarity in size between Weyburn and Knoxville, including the size of the local mental hospitals, made these "naturals" for comparison. Minor modifications were made of the Sommer and Dewar questions where it was felt appropriate. These items are to be found in Table 1.

RESULTS

The second part consisted of four open-ended questions. One question was devoted to each of the important dimensions being studied; i.e., attitudes toward the hospital and town relationship, toward employees, toward volunteer workers and toward patients. A critical incident to support each respondent's opinion was requested, but this was not made mandatory, for scoring purposes. These questions are to be found under the discussion section of this paper. The final section was items of personal information such as age, education, annual income, sex and occupation. Interviews were conducted with 199 townspeople, 98 employees and 58 volunteers.

Four summer employees, all college students, were used to interview each respondent in a face-to-face contact. Since Knoxville was not zoned, random sampling was used to collect data. The first house in each block of town where a person was at home was the criterion for selection. After the town had been covered, an analysis of percentage in each of three predetermined income groups was made. Then, employees and volunteers were selected to

match these levels. Both town and employee groups were about equally divided according to sex; however, the predominance of females who do volunteer work made it virtually impossible to find enough males to make a comparison in this category worthwhile.

In analyzing the data, the objective section has been presented by simple percentage comparisons, as was done by Sommer and Dewar (4), by town and by occupation. However, a more detailed comparison of the open-ended questions has been made, showing statistical differences where they exist. A chi-square test was made on all relevant comparisons.

Part I. Objective Questions

Noting Table I, the over-all comparison of the citizens of Weyburn and Knoxville shows some differences of opinion. In only a few instances (Questions 1, 2, 5, 13, 16) do there appear to be real differences, and these may be an artifact of changes in wording between the original questions and the one used in this study. Item 1 seems relatively unimportant, showing only that Weyburn residents are more likely to show-off the hospital. There are some differences on the other items that are difficult to interpret, such as the fact that more people in Knoxville feel they should be alerted when a patient runs away (item 13).

On the other hand, it can be conjectured that the employees at Weyburn are not as well assimilated into the functioning of community as they are in Knoxville (items 2, 5 and 16). Before considering the responses of Knoxville residents with the hospital employees and the volunteer workers, the fact must be mentioned that practically all of the volunteers are residents of towns surrounding the hospital rather than the local community. Thus, the large number

TABLE 1

*Comparison of opinions on objective items among townspeople of Weyburn, Saskatchewan, and townspeople, hospital employees and volunteers of Knoxville, Iowa, in per cent **

	Weyburn		Knoxville					
	Town		Town		Employees		Volunteers	
	Yes	No	Yes	No	Yes	No	Yes	No
1. When you have out-of-town visitors, do you ever take them out and show them the mental hospital; that is, take them around the grounds?	81	19	55	45	71	29	43	54
2. Do hospital employees take sufficient interest in community politics and affairs?	55	12	70	10	68	21	26	3
3. As a resident of this area do you wish Knoxville (Weyburn) didn't have a mental hospital located here?	5	92	4	96	2	97	0	95
4. In time of emergency or disaster, if the Collins (Union) hospital were full, would you favor sending patients out to the mental hospital here rather than to a general hospital in another city?	64	26	65	31	83	17	76	21
5. Do you think that the people of Knoxville (Weyburn) have enough to say about how the hospital is run?	40	23	51	11	67	6	43	2
6. Does the hospital give you enough opportunity to visit the mental hospital?	84	1	80	4	86	8	88	5
7. Do you feel people who work at a mental hospital are apt to be "odd?"	13	84	10	87	4	96	2	97
8. Do people in Knoxville hear too much about mental illness?	..	..	2	91	1	83	2	53
9. Do you think if there were someone in town who nobody else would hire that he could always get a job at the VA (mental) hospital?	9	80	10	78	2	95	3	85
10. Are the patients at the mental hospital given too much freedom in walking around the grounds alone?	8	86	6	78	3	96	2	97

TABLE 1—Cont.

	Weyburn				Knoxville			
	Town		Town		Employees		Volunteers	
	Yes	No	Yes	No	Yes	No	Yes	No
11. Has the mental hospital given the town a "bad name?"	4	93	1	98	2	95	0	97
12. Do you think the hospital hires too many non-white people?	7	83	2	75	0	97	2	95
13. Should the people in town be alerted when a patient runs away?	38	55	62	36	30	68	48	48
14. When the whistle sounds at the hospital, do you feel that this is a warning that a patient has escaped? (The whistle actually used only for fire or similar emergency.)			39	40	2	94	2	76
15. If you had young children would you let them ride bicycles or play around the mental hospital grounds?	26	68	24	75	28	71	26	74
16. Do most people who work at the hospital consider Knoxville (Weyburn) to be their town?	58	14	74	11	73	17	48	21
17. Do you feel too many patients are allowed to come downtown without a nurse?	11	70	16	65	10	84	9	46
18. Do you feel women are in greater danger on the hospital grounds than they are downtown?	..	..	23	71	13	85	3	97
19. Do you feel that residents of Knoxville take enough interest in the VA hospital?	41	31	41	34	31	49	14	43
20. Do you feel that working as a volunteer at the VA hospital would be dangerous to you or would affect your reputation in some way?	..	..	7	92	5	94	0	100

* Only yes and no percentages are reported here to conserve space, remainder figures up to 100 per cent constitute number of "don't know" responses. Minor differences in wording of the items of this questionnaire should be compared to the one used by Sommer and Dewar (4).

of "don't know" answers on item 2 do come, in all probability, from a genuine lack of knowledge.

Summarizing the outcome of the objec-

tive items, then, it appears that employees are more likely to take guests to see the hospital than are other respondents. They are also agreeable to the use of the hospital

for emergency treatment more than are townspeople or volunteers. There is a slight tendency for employees to believe townspeople have enough to say about the operation of the hospital.

Conversely, more townspeople tended to feel that employees were "odd," that the hospital would hire employees no one else would have, that women were in greater danger on the hospital grounds, and a surprisingly great number thought the town should be alerted every time a patient runs away.

There were some income differences on a few items. More higher income individuals, those who earned \$9,000 a year or above, were likely to visit the hospital, look favorably upon using local mental hospital facilities in time of emergency, believe that people have enough to say about running the hospital, feel that hospital employees accept Knoxville as their town, and assume that the presence of the hospital has given the town a bad name.

Lower-income persons, those whose income is less than \$4,000 per year, tend to believe that the hospital hires too many non-white persons, believe that they should be alerted when a patient runs away, and assume that being a volunteer is dangerous to them or would affect their reputation.

Part II. Open-Ended Questions.¹

These questions were classified according to essentially positive, neutral and negative answers. Two judges, one an experienced clinical psychologist and the other an advanced graduate student in psychology, judged each question according to prede-

termined criteria. There was a 93 per cent over-all agreement in judgments.

All questions showing disagreement were resolved by discussion between judges and included in statistical analysis. The results of these questions are reported in Table 2 in terms of significant differences of opinion between different groups.

Question I. This question reads as follows: Tell how you feel the large VA mental hospital in the community affects Knoxville as a town?

Replies were classified as positive when any benefits such as income, employment, education or service were mentioned. A response was considered negative when there was any suggestion of deterrence to community growth, wish the hospital not here or other sign that the community was being harmed. Neutral responses were "don't know," evasive or ambivalent.

A very high agreement (97 per cent) between judges on this question can be explained by the unanimity of respondents' opinions. Practically everyone agreed that the hospital had positive benefits for the town. For the most part, the benefit seen was an economic one. A few employees and volunteers viewed the hospital as a place where citizens who become mentally ill can be restored to health and productivity; others saw the hospital as providing community educational and recreational resources; and still others valued the high-level professional employees who raised the standards of the town.

On the whole, it was the payroll—the money—without which the town could not exist that most persons emphasized, regardless of the group in which they were classified. Perhaps not surprisingly, the men had significantly better opinions about the good effect of the hospital than did women.

¹ Actual percentages of responses have not been included here, but they will be made available upon request to the authors. No attempt has been made to exhaust the data (e.g., age differences) because of interest in only the broader findings related to the three groups interviewed.

In terms of raw numbers, however, most women did recognize the need for the hospital as the primary financial resource in town.

Question II. How do you feel that working with mental patients for a long time affects hospital employees?

Here was an area of great disagreement. As might be expected, there was also great

the less negative and more positive effect was seen.

Question III. Assuming that you have the time, would you become a volunteer at the VA mental hospital (For Volunteers: Over Again?) (For Employees: If You Were Not Employed Here?)?

Again, answers to the question were highly predictable, and consequently there

TABLE 2

*A comparison of opinions of residents, employees and volunteers where significant differences of belief occur **

	Total town x total employee	Town male x employee male	Total male x total female	Town female x employee female x volunteer female
I. Effect of the hospital on town	NS	NS	<.05>.02	NS
II. Effect of patients on employees	<.01	<.01	NS	<.05
III. Willingness to do volunteer work	NS	NS	NS	<.01
IV. Allowing patients freedom in town	<.01	NS	NS	<.05>.02

* Percentages will be provided those interested in more detail than provided by this table.

est disagreement among judges. However, a concurrence of 82 per cent still shows very high consistency. Responses were judged positive when the interviewee saw educational or emotional growth by employees or where no effect at all was indicated. A negative opinion resulted from ideas that employees become excessively nervous, depressed, irritable or physically ill. Ambivalent, indecisive and "cannot say" responses were considered neutral.

Employees disagreed very highly with the townspeople, as could be predicted. The same held true between town and employee males, and between town, employee and volunteer females. There were no sexual differences. On the whole, the more direct the affiliation with the hospital,

was great uniformity. Positive judgments were made when respondents stated that they would like to be volunteers or where they expressed a positive value. When they stated that they did not like that kind of work, that it was dangerous or of no value to patients, the answer was considered to be negative. Neutral responses included ambivalent, evasive or "cannot say." The agreement between judges was 97 per cent.

Notable differences of opinion were found between males and females, and among town, employee, and volunteer females. Women are more likely to have the desire to do volunteer work than are men. Volunteers agreed 100 per cent that they would volunteer all over again if it came

to such a choice, whereas both employee and town women were split about 50-50 even as to their desire to perform such service, let alone actually getting involved in it. Many of these women agreed they would do the work if they had to in an emergency, but only a few stated enthusiastically they would be glad to volunteer if they were just asked.

Question IV. Do you believe mental patients should be allowed downtown without escort under any circumstances?

Again, this question brought about a wide divergence of opinion. The agreement between judges was 95 per cent. Criteria for positive judgments were any recognition that freedom is usually good with doctor's approval, a necessary part of rehabilitation, etc. "Usually not a good something, harmful to business," etc, were classed as negative. Neutral were "cannot say," or "don't know" and ambivalent, unclassifiable replies.

The greatest disagreement on this question was between the employees and the townspeople. Fortunately, employees, on the whole, recognized the need for town passes and privileges as part of the therapeutic process. There was no question that occasional townspeople felt patients should not be allowed out under any circumstances, while a few felt that if they were well enough to go to town, they were well enough to be discharged from the hospital. There was no significant difference of opinion between town males and employee males, although there was a tendency for more town males to oppose the idea. However, town women and volunteer workers showed significantly more negative attitudes toward freedom for the patients than did employee women.

DISCUSSION

The findings from both objective and essay questions do support the fact that the community has a general feeling of good will toward the mental hospital in Knoxville. This coincides with the survey of Sommers and Dewar (4). However, a more detailed analysis of the first essay question readily suggests that objective items can lead to an oversimplified conclusion.

The majority of respondents from the town, and to a lesser extent from among employees and volunteers, view the hospital almost independently of its therapeutic function. Practically no one saw the rehabilitation of people into productive citizens as an effect. On the other hand, practically none saw the hospital as a stigma on the community because of its having mental patients.

The major issue was purely economic. The hospital provided jobs, a payroll, and other features that contributed not only to the growth but also to the very being of the town. For financial reasons, then, the hospital was seen as a positive asset to the community.

In ascertaining opinion about the effect of working with mental patients, it is true that no more than 10 per cent of the community believes that employees are "odd," but almost one-third of the townspeople think that employees are affected in some way. For the most part, it was presumed that employees became more irritable, nervous, depressed and even physically ill. Actually only slightly more than half the townspeople said that employees either were not affected or were improved through their contacts with the patients.

An unexpected finding was that 12 out of 98 employees interviewed also thought that employees were adversely affected by patient contacts. These must have been clerical workers. Of interest, too, is that

16 out of 58 volunteers stated that workers with mental patients would be changed in some negative way. One wonders, if they really do feel this way, what prompts them to run such a risk of danger themselves.

So, what were the attitudes toward volunteers? The volunteers seemed assured of the tasks they were doing, and agreed 100 per cent that they would do the same if they had it to do over again. Townspeople and employees were not as favorable toward volunteers, but held opinions in common; that is, only a very few wanted to do volunteer work. About half of these latter groups stated that in an emergency they would be glad to help out, but a predominant opinion was that there were other activities they would rather do. Only a very few people expressed truly hostile attitudes.

Because most of a hospital's volunteers are women, comment might be made in regard to item 18 of the objective questionnaire. Not a volunteer felt women were in any danger on the hospital grounds, yet several employees did believe this was so. For the most part, men workers seemed more afraid for the women employees than were the females themselves. The reader is left to his own interpretation. The rather large number of townspeople who considered women to be in danger on the hospital grounds were likely reflecting opinions that came out on item IV of the open-ended questions.

One-fourth of the townspeople seemed opposed, for one reason or another, to patients being allowed in town without an escort. A few suggested arm bands or other identifying marks to warn citizens that a patient is in their midst. Others cited instances where patients had molested townspeople, wandered into their homes or made threats. These were infrequent, but imply that a sizable minority of people have prej-

udices against the mentally ill. There was no significant difference between sexes. Employees tend to be most liberal and townspeople least liberal about allowing freedom to mental patients.

An interesting point is comparison of female volunteer responses on this question and on item 18. Although volunteers said they felt in no greater danger on the hospital grounds, significantly more of them were opposed to allowing freedom for the patients outside the grounds.

Finally, in taking an overview of the findings of this study, there are encouraging results. Most people do have positive attitudes about mental patients and those who work with them. Practically no one feels that a mental hospital detracts from the community. It is evident that enlightenment is needed on special problems before people will accept all the values and gains that have been made in the area of therapy and even the nature of mental illness. As was predicted, more negative attitudes were found among townspeople, fewer among volunteers and the least among employees.

Common agreement centered upon those aspects which could be largely dehumanized; i.e., the hospital, the town and the financial portions of their relationship. However, consensus became less common as consideration was given to patients. In fact, a continuum from communality to increasing discord of opinion between the three groups appears to follow a pattern, starting with greatest correspondence of attitudes toward the inanimate hospital, to volunteers, to employees, and finally to the freedom allowed for patients. Admittedly, this trend is the result of the writers' interpretations of the quality of answers to the four open-ended questions, but further study is certainly indicated.

Also, it is clear that favorable attitudes

toward a mental hospital by the community does not coincide perfectly with attitudes toward mental illness. On the whole, the city of Knoxville demonstrates predominantly good attitudes toward neuropsychiatric patients. However, there does exist a sizable minority who are poorly informed and even, in some instances, hostile toward progressive treatment. For these persons, considerably more education is needed on how patients are selected for privileges, on the nature of the employees who choose to work with mental patients, and on the purpose and prognosis of psychiatric rehabilitation.

CONCLUSION

A 1,500 bed neuropsychiatric hospital in a small Iowa town of approximately 8,000 citizens perceived problems in community relations. A random sample of 199 residents of the community, 98 employees and 58 volunteer workers at the hospital were interviewed in face-to-face situations.

An objective questionnaire used in a study of Weyburn, Saskatchewan, was used with minor modification. A comparison of the two towns demonstrated generally favorable attitudes toward the mental hospital. The addition of four open-ended questions relevant to attitudes toward the hospital, employees, volunteers and patients revealed that attitudes toward the hospital do not correspond completely with attitudes toward the mentally ill. Some generalization appears to spread according to the degree of perceived affiliation with the patient.

Conversely, the amount of involvement modifies perceptions too.

Taking a global approach to the data, the majority of all groups were fairly liberal in their outlook, but a sizable minority believe that people are affected by being around mental patients too much, that mental patients should not be allowed too much freedom around town under any circumstances, and grant minimal recognition to the value of the hospital as a vehicle for getting good citizens back into the community after a mental break-down.

The high agreement about the worthwhileness of the hospital is basically stemming from economic rewards; e.g., large payroll, jobs and some recognizable status among other communities within the state. Most extreme negative attitudes were noted in townspeople; least extreme were employees, while the volunteers, predictably, fell in between.

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An analysis of attitudes of professional personnel regarding mental retardation as a field

Whenever a community attempts to formulate an over-all plan designed to meet specific social needs, one common difficulty is that of obtaining adequately trained and experienced personnel.

This is particularly true in the area of mental retardation where "approximately three per cent of the school population are found to be mentally retarded" and where "the proportion of mentally retarded adults (not to mention children) in the general population who need special serv-

ices is approximately one per cent" (4, p. 18).

Albee (1, p. xvii) states that the 2,000 social workers trained each year does not approach the annual need, which he roughly estimates at from 4,000 to 12,000. Similar difficulties are apparent in attracting educational personnel. Heber estimates that "fewer than 20 per cent of the nation's one million school-age mentally retarded are enrolled in public school special classes" (5). He attributes this lack of classroom facilities to the severe shortage of qualified teaching personnel, and sees no cause for optimism in this regard.

A review of the literature reveals a pessimistic point of view concerning our ability to cope with the personnel problem in

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mental health. Albee (1) sees no prospect for significant improvements in the quantity or quality of professional services in the mental health professions.

In stressing the lack of effective recruitment, he points out that professional isolation is often mentioned as a contributing factor to the unwillingness of professionals to enter this field. The Committee on Psychology of the American Association on Mental Deficiency observes that society must provide "jobs of appropriate prestige and remuneration . . ." and that the various states must "review and re-evaluate the salary schedules for psychologists and other related professional workers in mental retardation" (2, p. 649).

Although many investigators have recognized the personnel shortages in mental retardation and have mentioned some reasons, there appear to be few investigations in this area.

Stimulated by the dearth of material in the literature and confronted with a practical problem of securing personnel (1), the authors became concerned with the attitudes of personnel in four professional disciplines closely concerned with the management of mental retardation; i.e., education, psychology, social work and medicine (2).

The purpose of this study was to provide some partial answers to the question, "What are the attitudes of professional workers in education, psychology and social work toward employment in the general field of mental retardation?"

It was hoped that this study would also provide information on certain specific questions such as: (1) How do the professional groups used in this study compare in terms of education and income? (2) What effect would financial increments above present income have on recruitment of needed professionals? (3) Are these pro-

fessionals interested in mental retardation as a work area? (4) What factors detract from and attract professionals to the general field of retardation?

METHODS

Subjects: Subjects for the study were psychologists, social workers and teachers employed by private and public agencies in Monroe County, N. Y. (3).

Instruments: A brief questionnaire consisting of eight questions and requiring approximately ten minutes for completion was distributed. A letter of explanation and a stamped, addressed envelope were enclosed with the questionnaire.

Procedure: One hundred sixty-nine questionnaires were distributed to individuals in the three professional categories: education, psychology and social work.

The obtained questionnaires were first analyzed for adequacy of response and to determine if, in fact, there existed a variety of attitude differences toward mental retardation as a profession. Then the responses were analyzed on the basis of those respondents involved in the field and those not involved. A further separation of the data into four distinct groups for additional comparative analysis followed.

RESULTS

Comparisons by Occupation and by Involvement

Eighty-five (50 per cent) of the professionals responded. When the sample was separated into two groups, those *not working* in mental retardation (A), and those *working* in mental retardation (B), Group A showed a significantly higher educational attainment than Group B. A further division showed the educational level of psychologists to be significantly higher than the teachers in the same sample. There

was no significant difference between the two teacher groups on this factor.

The sample was also divided on the bases of current salary, occupation and involvement in mental retardation.

Ninety-six per cent of the sample professional group had salaries in the \$4,000-\$10,000 range. Social workers and psychologists received significantly higher salaries than both classifications of teachers. However, there was no significant difference in salary between the two teacher groups, nor between the social workers and psychologists.

Relationship Between Monetary Inducement and Willingness to Enter Field

Analysis failed to reveal any significant differences in the relationship between monetary inducement above present income and willingness to enter the field of retardation. However, cumulative percentages indicated that additional income would be a factor in inducing about 80 per cent of these respondents to enter the field.

Preferential Rankings for Five Disability Groups

Significantly higher rankings of mental retardation were made by those working in mental retardation as compared with those not engaged in the field. The teachers of the retarded differed significantly from the social workers, psychologists, and elementary teachers in their rankings of this field. Again their rating proved to be higher.

No significant differences were found when the ranking by social workers, psychologists and elementary teachers were compared. Rankings of preference of these groups for the "emotionally disturbed" and "gifted children" were also compared.

Significant difference in the preferences

of the groups as compared with the teachers of the mentally retarded was found. The rankings of preference for "gifted children" by elementary teachers are significantly higher compared with all other groups. Rankings of "cerebral palsy" and "hearing," "speech" and "vision" fields revealed no significant differences.

DISCUSSION

It might be expected that psychologists' educational attainments, as indicated by degrees, would be higher than that of social workers or practicing teachers. However, the fact that the teachers of the retarded in this sample have a lower educational attainment than the elementary teachers should be considered. In this state (New York) the validity of a certificate for teaching common subjects, issued upon four years of approved preparation, is extended to include the teaching of the mentally handicapped upon completion of 12 additional semester hours of approved professional courses and a practicum.

Forty-three per cent of the elementary teachers had masters degrees, while only 21 per cent of the teachers of the retarded had attained that status. It is also possible that what Hechinger (6) has referred to as the "juggling of insufficient teachers between the special service and the elementary schools" has created a situation whereby lower academic attainment in teachers of the retarded is the rule and not the exception.

It might also be expected that specialists such as psychologists and social workers would be compensated at a rate above that of teachers. That the elementary teachers in this study received higher average salaries than the teachers of the retarded raises some question since the latter generally receive increments above the salary schedule.

However, the difference in compensation might be due to the inadequacy of the sample in this regard. No attempt was made to match these two groups for time spent in teaching. The reason might then be that the elementary teachers have more teaching experience and would therefore report greater compensation.

Regardless of whether they are experienced or inexperienced teachers, it would seem to be difficult from the monetary point of view to induce elementary teachers to switch their pedagogical allegiance to the retarded. This study indicates that it would take \$2,000 or more above present salary to entice 50 per cent of the elementary teachers (who indicate some willingness) to enter the field. Yet elementary teachers must be considered a primary recruitment source for teachers of the retarded.

Of the 45 professionals who responded to a question concerning monetary inducement, 20 per cent stated that no amount of money would attract them to the field. However, since 22 of the professionals in this study did not respond to the item it is reasonable to assume that more than 9 (20 per cent) could not be attracted to this field with any reasonable monetary inducement.

Inspection of the questionnaires revealed that those with the higher degrees are the highest salaried. Furthermore, those whose incomes are highest would require the greatest amount of additional remuneration to enter the field. This might mean that the most difficult to entice into mental retardation would be those people who are most capable, or at least those who have attained the highest educational level.

It has been stated unequivocally that "the major reason for the shortage of personnel in the rehabilitation field is inadequate salaries" (8, p. 12). The cumulative percentages show that 51 per cent of all

the professionals indicating any willingness to change at all can be motivated to enter mental retardation for \$2,000 or less. Of the social workers, 67 per cent would require this inducement, while only 35 per cent of the psychologists would change to this field for a like amount.

From this point on, however, the necessary increment becomes somewhat unrealistic. Almost three-quarters of all of the professionals polled would change to mental retardation for \$4,000 or less. The most realistic estimate of what inducement might be used would be a five per cent increment, since this is what is generally used in health and welfare services in this community and in other communities. In most instances, this would generally be between \$500 and \$1,000. This monetary inducement would attract approximately one-third of the professional people involved in the present study, with social workers and elementary teachers being slightly above that figure and psychologists being slightly below.

The willingness of any group of professional workers to move from one field to another is obviously based on more than a monetary factor. Preference, or what Super (7, p. 379) refers to as a "degree of interest or strength of motivation," must be considered. Of the total group, 41 per cent rated the field of mental retardation highest in terms of preference. However, the significant difference is shown to be the direct result of the high rating given the field of mental retardation by teachers of the mentally retarded. They provide a significantly different ranking of the field than do social workers, psychologists or elementary school teachers, all of whom showed similar preferences.

It is interesting to note that many of these professionals, excluding the teachers of the retarded, rank mental retardation

in a "neutral" position (third and fourth); i.e., 75 per cent of the social workers, 74 per cent of the psychologists, and 86 per cent of the elementary teachers. If properly oriented, as teachers of the retarded are considered to be, these seemingly "neutral" professionals might be able to shift their interest to retardation. The key to this shift might be exposure to the field.

This should not be taken to mean that the groups other than teachers of the mentally retarded are neutral where *other* disabilities are concerned. A seeming lack of interest in the field of mental retardation may not be the result of indifference; rather, it may be the result of *interest* in another area.

Few professionals appear to be interested in cerebral palsy (3, p. 3). This includes the teacher of the mentally retarded. Yet it has been variously estimated that cerebral palsy exists concurrently with mental retardation in 30 to 75 per cent of the cases. If it is difficult to attract professional people to the field of mental retardation without any qualifying condition, it would seem to be much more difficult to attract them to multidisabled patients.

In the sample group there were 30 responses to a question relating to how they entered the field of retardation. The reasons given were varied. Almost half of the responses from teachers of the retarded indicated entrance into the field was solely due to the availability of a position. Training exposure accounted for 13 per cent. Only one person in the group, an elementary teacher, responded that interest in the field was sufficient to motivate her to enter. Forty-three per cent of the entire number of respondents reported they entered the field through exposure either in undergraduate, graduate training and/or through work experience.

Twelve of the 19 responses (63 per cent)

made by teachers of the mentally retarded involved altruism in the sense of devotion to the interest of others. This "service" ideal was found to apply not only to teachers of the retarded but also to the elementary teachers in general. The social scientists, psychologists and social workers did not seem to feel this to be sufficient reason. They seemed more inclined to believe that the field of mental retardation offered opportunity for self-aggrandizement.

Of the psychologists, 64 per cent saw the field as offering opportunity described in such terms as "creative opportunity," "professional development," "self-advancement," and "research." Social workers seemed somewhat more service-oriented, although approximately 50 per cent of their responses indicated that opportunity would be a motivating factor, in contrast to 21 per cent of the teachers of the retarded.

There was more uniformity of response when the question was asked, "What reasons might you have for not entering the field?" Of a total of 86 responses, 69 per cent were negative. Twenty-two per cent felt the nature of mental retardation was static and 30 per cent felt they would not enter the field because it was depressing.

It should be pointed out that all of the professional disciplines sampled had ascribed similar feelings toward the nature of retardation, including the teachers of the retarded. These professionals listed reasons other than the static and depressing nature of the field. Their responses pertained to inadequate facilities and low salaries, both of which could be attributed to the low status of mental retardation. Lack of professional prestige and lack of recognition by supervisors were also seen as deterrents. Although no teachers of the retarded admitted a lack of interest in their field, about 17 per cent of the responses, evenly distributed among other

disciplines, did indicate other interests would deter entrance into this field.

SUMMARY

In this study a Vocational Interest Questionnaire composed of eight questions was sent to 169 professionals. Eighty-five (50 per cent) of these questionnaires were returned. Included were social workers, psychologists, elementary teachers and teachers of the retarded.

There is a significant difference between the teachers of the retarded and psychologists and social workers, with the latter two groups generally having more advanced study than the teachers. Neither teacher group was significantly differentiated by educational level. Although the teacher groups were not differentiated by salary, psychologists and social workers received significantly higher salaries than teachers of the retarded.

As to the motivation provided by a monetary increment, approximately one in two professionals in this study felt they could be induced to come into the field for an additional \$2,000 or more over that which they were already receiving. The usual increments of 5 per cent or possibly even 10 per cent would draw very few of those not already in retardation.

Whereas teachers of the retarded prefer to work with the retarded, they are generally alone in their preference. Social workers, psychologists and elementary teachers seem neutral about the field.

Of those who are or have been in the field, two factors stand out as responsible for their entering; i.e., available job vacancies and exposure in undergraduate or graduate schools and/or at work. For those who are not working in retardation, factors that might motivate them to enter the field would be job opportunity characteristics such as stimulation, creative

work activity, self-advancement, research possibilities, and professional development. In contrast, those who are in the field, primarily teachers of the retarded, feel that altruism would be the primary motivating factor for entering this field.

Over half of these professionals feel they might be dissuaded from entering the field because it is too static or depressing. Lack of interest of professionals, other than teachers of the retarded, is a further deterrent.

It has been noted that in each professional group investigated in this study, some of the professionals were neither willing to enter the field or were at least neutral about it. A study of the interests and aptitudes of these professionals might help to identify professionals in teaching, social work and psychology who might be willing to enter the field of mental retardation.

A tentative conclusion is that the field of mental retardation has built-in limitations rather than rewards. Because of this finding, it is suggested that a study of the advisability of merging programs of other disability groups should be explored and undertaken. Also recommended are studies involving the more efficient use of personnel in the field. In this connection the developing of core staffs in the agencies immediately involved in programming for the retarded, along with agencies working with other disabilities, ought to be undertaken as a possible resolution of the negative feelings of professionals relative to the field of retardation.

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Preventing mental ill health in early childhood

Among the many excellent aphorisms in the English language, few are as popular and often repeated as this: "An ounce of prevention is worth a pound of cure." From the earliest days of scientific medicine, when the Greeks assigned cure to the god Aesculapius and prevention to the goddess Hygeia, wise men have recognized the essential difference between these two activities among healers and teachers of men.

We have recognized their difference but also their interdependence. It was always known that if one was a faithful worshiper of Hygeia, then perhaps one would not have to call on powers of Aesculapius. But we have always been much more awed by the potency and magic of the healer and curer than we have by the pedestrian wisdoms of the preventer. When Aesculapius became so mighty in his healing powers that he even succeeded in reviving the dead, Zeus had him put to death. Apollo inter-

vened and persuaded Zeus to resurrect Aesculapius in the form of a God. It was not the first nor the last time that death yielded transfiguration.

Thus, we have always regarded with awe and mystery the powers of the healer. As for the patient and unassuming protectors of the public health, we have held them in a much more casual light. Unless my knowledge of Greek mythology fails me, I am not aware that anyone ever tried to kill Hygeia for her extravagant successes.

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Yet it is only right that Hygeia, too, should have been elevated to godhood. The ounce of prevention, no matter how hard to come by, is certainly worth the pound of cure. Today, with our many recently undertaken studies in the epidemiology of mental illness, we are more aware than ever of the great need to eliminate this agonizing problem.

The recently issued volumes of the Joint Commission on Mental Illness and Health (12, 13) present us with a wealth of documentation establishing the proliferating roots of mental ill health and its connection with a multitude of related social problems, such as delinquency, poverty, and alcoholism. A recent study of mental health in Manhattan concludes that as many as one out of four adults has levels of mental ill health requiring treatment (16).

It is clear that mental disorder has now emerged as our leading public health problem. We have all but wiped out general paresis. Soon we will defeat arteriosclerosis, senile deterioration, cancer, heart diseases, and certain varieties of mental retardation. All of these may one day be eliminated from the crucial roster of medical concerns, just as blacksmithing, once a flourishing trade in America, has all but disappeared in the farms and villages of our country. Just as the automobile replaced the horse, so the disenchanted mind is about to replace the deteriorating flesh. Perhaps we may look forward to the day when the sad state of our immortal souls will pre-occupy us more than the agitated condition of our mortal minds.

It should be said at the onset of this presentation that it is a serious mistake to assign the achievement of mental well-being exclusively to the clinical professions. No profession and no discipline has a

monopoly on that phenomenon we call the mind. Physicians, surgeons, neurologists, psychologists, psychiatrists, psychiatric social workers—no one of these acting alone or in concert can secure among men those benign relationships which are the only guarantee of mental well-being. Mental hygiene must be a major concern of economists, administrators, sociologists, statesmen, and above all, educators.

In discussions of physical and mental illness it is common to distinguish between three levels of prevention: primary, which is the prevention of the occurrence of the illness; secondary, which is the early diagnosis and treatment of an ailment to prevent its worsening and its progression to more aggravated states; and, finally, tertiary prevention, which is the control or mitigation of advanced conditions of illness, or rehabilitation when a disease has run its course or has been arrested. Some authorities also consider postponement of death as an aspect of tertiary prevention.

In a recent paper reviewing secondary prevention in child psychiatry, Leon Eisenberg and Ernest Gruenberg (4) point out that there is convincing evidence of our ability to prevent many toxic psychoses of childhood through prompt treatment, and that it is possible to intervene effectively in certain infections of the central nervous system as well as in certain psychogenic disorders, such as those resulting from maternal deprivation and environmental impoverishment. Also, there is evidence that school phobia, a neurotic disturbance of childhood, can be successfully treated in the early grades.

With respect to the outcome of large scale studies of outpatient psychotherapy, the results are less conclusive (4, 3, 8), but there is some evidence that neurotic and personality disorders of childhood can be

treated, with beneficial results. Specifically, there is much to recommend short-term intervention on the diagnostic or treatment level, especially if we are willing to settle for symptomatic amelioration.

There is, unfortunately, no conclusive evidence that any of the many therapeutic efforts made on behalf of the psychotic child are effective.

Eisenberg and Gruenberg make two specific recommendations worthy of serious attention. One is that we ought not to confine availability of service on the level of secondary prevention to those cases which happen to coincide with staff competences and preoccupations, which may be arbitrarily determined.

Thus, they say:

"It is not uncommon for child guidance clinics to have an over-all policy of refusing treatment to brain-damaged or mentally defective children. Yet the implications of present information is that perhaps more can be offered certain brain-damaged or defective children than bright but severely neurotic or psychotic children. This is not to suggest that treatment be refused the latter group but that priority for treatment be assigned on the basis of careful review of what treatment can contribute to community health rather than biases against certain clinical entities or predilections for others" (4).

Their second recommendation is to the effect that while we may always want to involve parents or the responsible caretakers in the treatment of troubled children, we ought not to make this a hard and fast rule, since some cases can be treated effectively with minimal or almost no parental involvement.

In the remainder of this paper I will be concerned almost exclusively with primary prevention and, moreover, with primary prevention in a social and communal rather than in an individual sense. As Caplan (2) and others have pointed out, while we may

be a long way from predicting or preventing the occurrence of mental disorder in the individual child, we do have the obligation and possibility of initiating programs of primary prevention in broad and defined populations of children. Thus, primary prevention of mental disorders in early childhood is herein considered an aspect of social medicine, social psychiatry, or, even more broadly, sociology and social work.

Although mental health or mental ill health must be an ever-fluid system of events resulting from extremely complex clusters of experience which we now classify into convenient categories of biological, psychological, and social factors, we do not now possess enough knowledge to describe the events systematically.

Thus, we are forced to discuss rather artificially the separate categories, to speak rather vaguely of factors and conditions which blend into each other, and which combine and re-combine in all manner of ways, and which may yield quite different results, depending on time, place, previous occurrences, and so on without end.

In any event, to practice preventive social psychiatry or social work means to do something to the physical, mental and interpersonal world of the child so as to influence the future to be one way rather than another. We do not *intervene* in the life space of the child; rather, we *prevene*. We anticipate; we come before the event; we restructure some sector of the inner or outer environment of the child. To be engaged in primary prevention rather than secondary prevention or the process of curing and assuaging means to *prevene* when necessary in the physical and organic development of the human body, to *prevene* in the minds and hearts of men so as to influence or alter their ways of perceiv-

ing and believing, and to prevent in the social relationships which prevail among men.

There is a vast and rapidly accelerating body of research in the biological sector. Since this is an area in which I do not possess competence, I will merely make brief referral to these very significant studies. These researchers give dramatic evidence to the nature of science as a process whereby more and more of what was once assigned to vague and ill-defined spiritual or behavioral states becomes clearly identified as a predictable and controllable condition.

For the last 400 years this change in the nature of our understanding has been gathering momentum, and despite the elaborate, rich, and often-rewarding Freudian digressions of the past 60 years, this process is not now abating. Science continues to transfer data from the pot labeled "moral-spiritual-psychological" to the pot labeled "physical-chemical-biological."

With reference to severe mental disorders of young children, it is quite possible that within a generation or two almost all of what is now termed emotional or behavioral disorder will be clearly explainable in terms of the new interdisciplines: neuropsychiatry, biochemistry, psychopharmacology. For the time being, we must settle for such unsatisfactory designations as psychosis, mental retardation, brain damage, or central nervous system dysfunction.

With respect to the mental retardations, we are now witnessing crucial research on genetic factors, including disturbances of protein synthesis, and various polygenic abnormalities. We also know much more about certain dangerous perinatal conditions which might precipitate impaired mental functioning.

Exciting and large-scale research is now

under way to uncover and specify prenatal factors which yield neuropsychiatric disorders. One such study, being conducted by the National Institute of Neurological Diseases and Blindness, entails a long-time investigation of 50,000 mothers, and requires the co-operation of 15 research centers (10).

Through such studies we may anticipate the discovery of quite precise factors which determine the outcome of pregnancy, and in so doing we may, through careful counseling and community action, significantly prevent on the biological level and reduce the incidence of mental illness.

Another example of ongoing research which may yield ways to prevent at the perinatal level of development is the work at the Perinatal Physiology Laboratory in San Juan, Puerto Rico. Here, studies are focusing on the brain waves of fetuses of the rhesus monkey, in an effort to determine whether certain levels or varieties of stimuli applied to the mother may have an effect on the unborn organism. If it becomes possible to determine normal and abnormal states through analysis of the brain waves of the developing organism, this may carry significant implications in preventing noxious influences during pregnancy from culminating in biological disturbances of the newborn.

Turning now to attempts to prevent with the focus primarily on the psychological level, we encounter a broad variety of approaches and experimental projects. Many of them may be grouped under the simple classification of education or re-education, and it is possible to include counseling and psychotherapy as a subgroup under this heading.

We have a large number of programs centering on parent education and family counseling. Here the attempt is made to

influence adults by way of the mass media and individual and group discussions so as to yield changes in knowledge, understanding and behavior. These changes, it is hoped, will result in more valid methods of child care and will promote improved home and community atmospheres.

In a recent major review of the research in this area (1), Orville Brim, Jr., is forced to the conclusion that there is very little convincing data to substantiate scientifically the hopes and claims of parent-educators in their role as preventive mental hygienists. Yet, this is hardly a cause for despair or for moves to abandon the rich field of parent and family life education, since it is quite possible that the research designs are themselves inadequate, or that the results are so small and cumulative that no single study will reveal them. In any event, we do know that childrearing practices have altered dramatically over the last century, and we must conclude that these changing patterns have been the result of some specific factors. In some way, parents are being educated to change patterns of childrearing.

Certainly it is logical to suppose that if physicians in well-baby clinics, nurses in public health centers, counselors in family service agencies, and teachers and guidance people in the public schools can prevent in the attitude formation of parents and future parents, and in so doing influence them to abandon negative or destructive ways of handling children, then this must yield some beneficial results.

Some have suggested that we need a new type of child welfare professional, a person trained in a certain cluster of empirical skills from the areas of child psychology, nursing, and social work, and utilizing these skills in strategic centers such as prenatal clinics, daycare centers, or kin-

dergartens. Such professionals might work independently or as adjuncts to a clinical or educational team.

What is needed, therefore, are greater empirical trials and explorations in methods of parent education. A great deal of work needs to be done to take up this challenge.

There is one conceptual model of personality development which has stimulated a certain line of research and speculation concerning the primary prevention of childhood disorders. This is the "crisis model" of behavior, which postulates that there are certain relatively short critical periods in human development, during which accelerated or crucial changes may occur (2, 15). This, in turn, suggests that as the growing personality passes through these crucial periods, typical crisis-coping patterns emerge or become reinforced. Assuming that a child has repeatedly unsuccessful or damaging experiences in meeting these turning points in life development, we may end up with a disturbed human being.

It is clear that if a crisis represents a potential danger, then it may also constitute a potential reward in terms of personality development. Now, whether or not this conceptual model proves valid as a personality theory, there is no denying that it affords particularly practical ways of preventing in the psychological and social development of the child.

For example, one study conducted some years ago at the National Institute of Mental Health (2), postulated that two-year-old children who are separated from their mothers to attend nursery school are thereby made to undergo a crisis or transition period in their development, since they must learn to cope with the fact of maternal separation. If we study closely the be-

havior of such children in adjusting to a major change in their daily routine, and if we can then codify what appear to be typical and atypical, healthy and unhealthy ways of responding to the situation, we have then succeeded in establishing a certain checkpoint in the mental well-being of two-year-olds.

This alone may not, of course, be a conclusive checkpoint, but in combination with other data, observations, or past history, it may enable us to judge in some objective way whether a specific child is in good health, or exhibits certain suspicious signs which require watching, or some sort of preventive intervention.

It ought to be pointed out, in evaluating this concept of a mental health checkpoint, that this procedure does not in itself constitute positive primary prevention, for merely to identify is not to change, any more than the fact of a dentist's discovering a cavity constitutes having one's teeth fixed. Nevertheless, this approach does seem to open up exciting possibilities.

It goes without saying that the definition, establishment, and implementation of a community-wide program of mental health checkpoints immediately confronts the public health specialist or mental hygienist with an entirely new and bewildering set of problems having to do with such matters as finance, community organization, and political action.

Before leaving this discussion of psychological factors it may be well to say a word about psychotherapy as a means of primary prevention.

Enthusiastic writers of the psychoanalytic schools often leave a reader with the impression that the only genuine and fool-proof program for eliminating mental ailments would be a total program of preventive analysis. Since, in one degree or another, we are all susceptible to mental

failure, and since the psychological sins of the ancestors leave the offspring peculiarly vulnerable, perhaps every American adult ought to submit to a preventive psychoanalysis.

From the viewpoint of economics and logistics, however, it seems highly unlikely that we will ever succeed in maneuvering the American nation into a position where 50 million of us are on the couch and the other 50 million behind it; thus, there seems little point in pursuing this as a realistic program of primary prevention.

Moreover, in view of what might be said about the connection between cultural beliefs and values and the function of the psychotherapist, we are always nagged with the suspicion that the man behind the couch may not be in substantially better shape than the man who is on it. For a particularly sharp and slightly malicious fictional commentary on this theme, see a short story which appeared some time ago in a national magazine (14).

In any event, we ought to be cautious in our claims about the results of psychotherapy, many of which are contradictory. There are studies which show enthusiastic results, but there are also those which show little difference between treated and non-treated children (7, 8).

Over and over again, no matter how earnestly we may try to discuss prevention by confining it to the biological and psychological sectors, we are compelled to confront the sociological influences. Over and over again, in the studies, researches, and reports on primary prevention, there loom in the background the mundane and inescapable conditions under which mothers, fathers, and children live out their lives. We confront problems of housing, jobs, travel, money, prejudice, the struggles for status and security. Over and over again, the ponderous and learned

discussions on anxiety, guilt, shame, self-concept, aggression, negativism dissolve into the daily facts of daily living.

In a recent authoritative and impeccably documented study, *Wealth and Power in America*, Gabriel Kolko (6) has demonstrated that income distribution in the United States is not substantially different from what it was in 1910. Today, 10 per cent of the population controls almost 40 per cent of the wealth.

Certain academic and cloistered economists are busy generating the myth that all Americans dwell in middle-class, suburban affluence, but the fact of the matter is that we in the U. S. are a nation with more than six million on various relief rolls, at least five million without employment, over two million agricultural laborers who exist in downright squalor, and with 30 per cent of our factory workers earning annual incomes of less than \$3,000. And anyone who knows the face of America does not have to be told under what conditions the vast majority of our 20 million Negro citizens pass their lives.

With more than one-third of our families compelled to get by with incomes that lead to violation of the minimum standards of physical health, nutrition, housing, and all the rest, how can we expect positive mental health to prevail in the land? What good will it do if we erect a friendly neighborhood mental health clinic on the corner of every city block—right next to the friendly neighborhood saloon—as long as we continue to have rat and cockroach infested slum housing, and parents who are so preoccupied with keeping body and soul together that they simply do not have the spiritual strength and peace of mind necessary for good childrearing?

The ever-present contradictions, the blatant antitheses in our culture and styles of living in the United States contaminate

all efforts at making neat biological or psychological assessments. Poverty and disease, miserable slums and job insecurity, malnutrition and primitive cultural aspiration—all these clash with luxury and precious neurotic drives, gaudy suburban dwellings and inane occupations, overnutrition and pseudocultural pursuits.

There are those who have neither the time or inclination to search for values or even to know what such a search is all about, and there are those who seek continually and never find. In the United States we sanctimoniously worship a God of lovingkindness and feverishly devise monstrous weapons designed to destroy all life on earth in as much time as it takes to read this paper.

We are all of us besmirched by these terrible contradictions, and by our inability to live consistently above the animalistic level. Is it truly possible to speak of good mental health and primary prevention in such a world?

Our society is so constructed that it deliberately violates one of the basic insights about human nature. There is nothing new about this insight. It is as ancient and venerable as the roots of scientific medicine and the origins of systematic philosophy. It was known to Hippocrates and is embodied in the oath which carries his name. It was known to Plato and Epictetus, to Avicenna and Maimonides, to Johann Weyer and Philippe Pinel. It was made the cornerstone of Harry Stack Sullivan's psychiatry, although Sullivan certainly did not invent it.

This powerful insight asserts that it is the relationships which prevail among men as individuals and as members of a structured society that ultimately determine their basic states of mental health and spiritual well-being. It is possible to have a strong and healthy mind in a weak, even

a tortured and devastated human body. The example of Helen Keller comes to mind. But to have strong and healthy *collectivities of minds* we must have healthy social relationships.

To have societies where creativity and vigorous altruism prevail, we must have a social structure which fosters altruism. To have free, strong and happy men and women, we cannot tolerate social conditions which breed inferiority, insecurity and systematic exploitation of certain segments of society by other segments.

It has been peculiarly difficult for us in the United States to act on the wisdom of this ancient insight. Only very gradually has our concept of therapy come to approach this wisdom. Individual therapy yields milieu treatment. Milieu treatment becomes more broadly conceived as the therapeutic community.

The process will not be ended until one day we will no longer need to think of therapeutic communities because we will have achieved a world-wide community where man's free and uninhibited rationality and creativity will have abrogated the need for what we now call "therapy." Perhaps it is a long way off, but it is the only ideal vision that will suffice. We dare not settle for a series of digressions and feeble meliorisms.

Yet, this is not for one moment to deny the need for certain melioristic endeavors, or the need for functioning at the level of secondary and tertiary prevention. But we must understand that the primary prevention of mental disorders in childhood, once we have eliminated from consideration the "purely" biological varieties, is a fundamentally different order of work from that of primary prevention in other areas of public health and social welfare.

We may cite for comparison the problem of accidents in early childhood. Recently

we have come to pay more and more attention to the problem of accident prevention. We no longer think of accidents as being merely "accidentally" determined. Specific patterns, causes, factors have been isolated. We can compile accurate statistics; we can make accurate predictions.

We know that teenagers are particularly prone to fatal accidents, that people who live in the rugged state of Alaska have twice as many chances of dying an accidental death as do residents of the more sedate state of Maryland, that there is a death peak between June and July (drowning), that the ratio of male to female deaths between the ages of 20 and 24 is 6:1, and that all infants and children who die between the ages of 1 and 14 are much more likely to be the victims of accidents rather than cancer, congenital malformations, pneumonia, or gastrointestinal disorders, which happen to be the most fatal diseases of childhood (11).

We also know that of the children who are killed accidentally between the ages of one and four, 75 per cent of them die of the following causes in descending order of importance: motor vehicles, fires, drowning, poisons (17).

All of this and much more we know and we know accurately, and concerning all of this we are doing a great deal. In the area of accident prevention we are moving with deliberate, logical, scientific speed and earnestness. We have achieved much and we will doubtlessly achieve much more.

We are able to do this because it is not necessary to make drastic changes in a social order in devising ways of keeping four-year-olds from drowning or in improving road safety so that fewer five-year-olds will be killed in automobiles. True, there may be many economic and social conflicts which slow up the process, but we are united in the belief that it is good to keep

four-year-olds from drowning, and we can rely on Yankee ingenuity to make cars safer and still protect the profit motive as it operates in Detroit.

But what Yankee ingenuity are we going to rely on when it comes to convincing the physicians of our nation—those whom we depend on for guarding our physical well-being and who in considerable measure must be responsible for implementing the principles of primary prevention of mental disorders herein being discussed—how shall we convince these physicians and the American Medical Association which represents so many of them that all American children must receive adequate medical attention without regard to the economic or social or racial status of their parents?

How are we going to convince the medical profession of the United States that the physical and mental well-being of this nation is more important than their imagined private prerogatives? Where is the Yankee ingenuity that will convince them that health care for the aged through social security is a basic contribution to the mental well-being of all the nation, that one cannot with one hand write papers praising primary prevention, while with the other hand one is signing petitions threatening to boycott medical services to the aged in the event that a certain measure is passed? Who is there among us that will rise up and say to the physicians of the United States what Jesus quoted to the Nazarenes: "Physician, cure thyself"?

As mental hygienists we have long been skirting a major responsibility. We have been perpetuating a silence that must be broken. As long as we continue this deliberate or witless conspiracy of silence, we shall make a mockery of the ideal of prevention, and we shall walk the same old treadmill of self-defeating acts.

The primary prevention of mental ill health does not have one precise locus. We cannot point to one action, one event, one mechanism, one area of intervention and say: this is the danger spot; this is where we do the preventing.

Indeed, in the final analysis we cannot prevent mental dysfunction in the way we speak of preventing typhus or polio, with inoculations or public health measures. There are no inoculations or public health measures that yield a healthy mind or a tranquil, loving soul. We prevent mental ill health through acts of universal promotion—through promoting social relationships and social structures which yield physical well-being, the general security and creative living patterns for all of mankind.

We shall be forever doomed to failure if we persist only in seeking to invent techniques of prevention, only in weaving subtle theories of human personality that will reveal the vulnerable crisis points, only in forwarding still newer and more fanciful fashions in psychotherapy. We are merely reshuffling the deck; the cards remain the same. Until we learn to prevent as well in the social order, there will be no real primary prevention.

In the United States today we do not yet possess a true philosophy of primary prevention, because we do not yet have clear convictions on how we must prevent in the social order. We do not yet have genuine programs of primary prevention because we are so committed and over-committed to symptomatic treatment methods.

We seem powerless, each of us in our own professional identities, to move in the direction of collective efforts, to regroup social forces with fearlessness and selflessness. At bottom, with the prominent ex-

ception of certain vital social security measures inaugurated in the 1930's, we in the United States are still operating in a framework of nineteenth century concepts of charity, although we heatedly deny this.

What is needed is the strength, the audacity and the courage to sustain the broadest possible vision of man's ultimate potentialities, of his proved capacity to remake his own nature (9), while at the same time working within the contemporary framework and its incredibly flexible limitations. So much is possible, and so much is impossible.

We must have the courage to plunge into action despite the waves of ignorance and despair which pound all around us, despite our painful awareness that it is the destiny of man not to leap from ignorance and evil to wisdom and goodness, but rather to traverse an unknown road from error and limited vision to less error and less limited vision.

As teachers, nurses, counselors, parents, physicians, we too plod along this endless path which began in the times when the ice covered our planet and a frail thinking creature emerged to fashion tools and to be fashioned by them. It is our task to carry this creature another step along the path and, while so doing, to diminish pain, to remove obstacles, to forestall error and failure.

But this is work not of prevention but of promotion. In the last analysis we will prevent those nonbiological failures, dysfunctions, errors and miseries of behavior which we lump together and call mental illness only if we are bold and courageous in promoting those still tenuous and primitively developed capacities of man for tenderness, empathy, altruism and selflessness.

What, then, is true prevention? It is the continual creation and re-creation of a

world which fosters these capacities among men.

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Observations on socioprofessional factors mitigating against the psychological care of hospitalized children

Social and professional precepts stress the hospitalized child's right to care which bends every effort toward minimizing unnecessary pain, fear and emotional anguish. This is more than merely a particular philosophy or abstract ethical position on the care of children.

There is considerable evidence that purely medical and custodial management of hospitalized children often results in emotional effects that go beyond the child's current adjustment to the hospital, producing psychological disturbance of a longer or even permanent duration. Various lines of evidence suggest iatrogenic psychopathology as an important public health issue.¹

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¹ Stein, A., "Resistance to Psychological Prophylaxis in Hospital Pediatrics," *Journal of Pediatrics*, 55(October, 1959), 497-503.

Despite the congruence of social values, professional ethics, and urgings of pediatric and mental health workers, relatively few hospitals make maximum reduction of children's anguish a matter of outspoken, active, and carefully implemented hospital policy. Hospitals provide many attentions and services aimed at keeping the child happy. Although heartfelt and representing great improvement over past situations, this type of emotional care is usually piecemeal and unco-ordinated, falling far short of minimum mental health requirements.

These observations should not cloud the fact that many exceptions and pioneering efforts do exist.

Can we solve the problems of psychological prophylaxis in hospital work by intensifying the research concentration on the psychopathological phenomena, or by increasing the amount of discussion and appeal on this subject? In view of experi-

ence to date, it is not unlikely that new findings and new appeals will be as isolated from current hospital practice as the old have been. We must look, therefore, at those factors which impede the translation of converging social, medical and mental health precepts into actual hospital procedures geared to the prevention of psychological distress and malady in children.

Objective formulation of the *resistance to psychological prophylaxis*² promises guidelines for effective remedial action and, thereby, for a closer realization of medical goals.

This paper raises and discusses some of the relevant issues. It is written in the hope that it may stimulate interest in these problems and contribute toward more sophisticated understanding and solution of them.

"RESISTANCE" AS CRISIS IN SOCIOPROFESSIONAL MATURATION

The psychosocial deficiencies of children's hospitalization make it "... easy to slip into satire in describing a children's ward." Because of this, the critic may fall into the error of overlooking the historical context of present orientations and methods.

In discussing Charles West's opening of the Hospital for Sick Children in London's Great Ormond Street in 1851, Spence^{3, 4} emphasized: "The forms of human institutions are predetermined as much by the age in which they are set as by the men who set them." Spence stated: "In this instance the age overcame the man." He traced some effects of that epoch on the children's ward, effects we still suffer from today. But did the era overcome the man?

When Charles West opened his hospital, one-third of the babies whose birth he attended died before their twelfth year. Those that pioneered children's facilities faced great needs and unrelenting tragedy.

Given primitive conditions and limited resources, a narrow concern with medical malady had a pervasive logic. It focused the resources of the hospital on the most essential aspect of its responsibilities: the maintenance of life and the reinstatement of physical health.

From this standpoint, the negative influence of Victorian times on the children's facilities of that day, of which Spence speaks, had functional counterparts. The "overdose of Shaftsbury and Dickens" may have been instrumental in the mustering of social effort for an attack on children's diseases. Many features of the ground-plan provided by the existing adult wards were, indeed, ill-suited for children. Nevertheless, it provided a practical framework for the newer children's facilities. The shallow conception of children's dependency and their emotional needs may be understood as a negative aspect of the anxious concern with physical survival.

One's empathic emotional reactions are important for active humanitarian involvements but, if too strong, they may dissuade involvement. Could it not be that, in an age of high pediatric illness and mortality, the groundwork development of children's facilities was made more effective by ignoring the child as an emotionally reacting individual? Such hardening of feeling is of help in first-hand acquaintance with children's illnesses, debility, mortality, their anguish at the separation from loved ones, and living in emotionally stark settings.

However psychologically maladaptive is

² *Ibid.*

³ Spence, J. C., *The Care of Children in Hospitals*, the Charles West Lecture delivered at the Royal College of Physicians, London, November 19, 1946. Reprinted by the Federal Security Agency, Social Security Administration, Children's Bureau, Washington 25, D. C.

⁴ *Ibid.*

the traditional type of pediatric hospital care, it was humanistically and medically adaptive in the sense that it allowed the work of hospital pediatrics to grow and prosper. Like immature phases of human development, we may construe the traditional psychomedical conditions of the children's ward as a *developmental phase* of this subsocial entity, and, much like difficulties experienced by the individual who cannot assume age-graded responsibilities, we may construe the resistance to psychological care and prophylaxis as a *developmental crisis*.

The essence of what may be termed "developmental crisis" is that it is thrust upon the individual by his very development. Likewise, it is the very success of the hospital enterprise and the great progress of medical (and psychological) science which outline and highlight the resistance to psychological prophylaxis and structure it as a maturational issue.

The progress of medical knowledge and art, together with the development and strengthening of the hospital as a socio-professional instrument, have changed the conditions of hospital practice. The prevalence of medical crisis and likelihood of pediatric death have been considerably reduced. A large percentage of hospital admissions are diagnostic or elective.

Except for a relatively small minority of cases, hospitalization has become a common (too common!) physically benign interlude in American childhood. Considering this, it is exceedingly difficult for the medical worker to justify a narrow disease-orientation toward the hospitalized child.

A second source of progress tends to shatter traditional institutional orientations to the pediatric patient. In the last decades, there has been far-reaching progress in psychological science, covering many such matters impinging on medical prac-

tice as mother-child interaction, children's cognitive and emotional development, environmental stress and its effects, psychopathological behavior, and so forth.

A major literature has accumulated regarding medical experience and children's psychological well-being. Since various conditions of institutionalization are now defined as harmful to psychosocial development, the physician, willy-nilly, is forced to face the problem of psychological prophylaxis in his hospital work. This is also reinforced by the growth of popular lay interest in children's development and mental health.

The typical children's ward, therefore, is under considerable pressure for self-advancing transformation in its organization and function in the direction of enlightened mental health management of its patients. Our problem is to try to understand why this has not occurred as a matter or rule rather than exception. The postulation of a resistance to psychological prophylaxis supposes that the absence of this sociomedical growth is the result of factors inhibiting or counteracting the tendency of the hospital to evolve progressively effective and self-satisfying methods.

This is also to say, for reasons intrinsic to this discussion, that inadequate psychological care of sick children is not the result of simple "backwardness," "social lag," lack of knowledge, or paucity of resources, which are the basis of most commonly given explanations for the hospital's deficiency in this area.

PROBLEM OF COMMITMENT

Effective psychological prophylaxis requires:

- (A) Strong self-indoctrination;
- (B) Strong and dedicated leadership;
- (C) A realistic and careful organization

of the children's ward and hospital for comprehensive psychological care.

Each of these areas has its difficulties, and is discussed in turn.

In some ways, the problem of self-indoctrination is not difficult. The main outline of psychological prophylaxis is accepted by most, if not on mental health grounds, then on the basis of simple humanitarianism. At other attitudinal levels, however, there is bias against serious involvement with the psychological aspects of the child's medical care and management.

All of medicine is a mixture of art and science. But the ingredients and balance of this mixture, the interest, aptitudes, and knowledge required for medical diagnosis and treatment are not always congruent with that required for dealing with the psychosocial aspects of a case.

Biomedicine is oriented to a "thing-world" of blood, organs, microbes and drugs, stressing quantifiable and reproducible methods. The sphere of the psychosocial is the introspective and interpersonal world of emotion, aspiration, thought and prejudice; it involves poorly quantifiable verbal methods and many variables which cannot be organized according to well-worked out canons. Because one is initiated, active and interested in either the biomedical or psychosocial sphere, this does not guarantee one's interest in the second.

Actually, the history of medicine involves an antipathy to psychiatry. Although today there are many cross-currents of change and development, the psychosocial sciences have a lower status relative to the biomedical disciplines; they tend to lose out in the tremendous competition among the special fields for the attention and time of the medical staff.

We might distinguish, then, between

passive agreement with a principle and active involvement with it. All agree with making the child's stay in the hospital as much a positive psychosocial experience as is realistically possible. But "living" this principle means much more. It means fact-gathering, discussion and searching for and implementing of solutions. It may mean work investments not directly related to one's special interests or self-advancement, or examining one's feelings and attitudes regarding the pediatric patient for proclivities and prejudices which can threaten an impartial respect for the rights of children.

DILEMMAS OF LEADERSHIP

In day-to-day medical practice with children, the physician functions as an important behavioral authority. Parents seek his help on many different kinds of childrearing problems. The very nature of hospitalizing a child places far-reaching psychological management responsibilities squarely on his shoulders.

Not too long ago, the special observation of the physician in professional practice, together with his reading and understanding distilled from human experience, was a basis for expertness on children's behavior. Recent decades, however, have witnessed an enormous expansion of psychological science, a fact sometimes hidden by achievements in the medical and physical sciences. Today, authoritative knowledge of children's behavior cannot be assimilated without its appropriate and special study. As a consequence, the physician often finds himself in a difficult position.

The physician selects out from his training and practical experience as much as he can for purposes of doing his important behavioral job. To a large degree he succeeds, but unless he has involved himself

in serious study, he does not picture himself as a behavioral expert. This reality has some important dimensions for the problem of the psychological care of hospitalized children.

Evaluation of research and recommendations require special and complex knowledge. This is as true of psychological research as it is of the research produced by the biomedical specialties. The competent, nonpsychologically trained physician rightly does not feel competent to judge the quality and merit of the psychological studies of hospitalized children.

Because comprehensive and effective mental health care of hospitalized children is impossible without blending complex psychosocial information into medical practice, he doubts his ability to undertake directly the planning and development of ward programs geared to this end. Resistance to psychological prophylaxis may be partially explained in terms of a resistance to changing the traditional ward organization and sociomedical activity in a direction requiring authoritative knowledge, which the physician does not feel qualified to give.

Why should lack of authoritative knowledge in the behavioral sphere hinder the sociomedical development of the children's ward? The need for specialized information in medical practice is satisfied through consultation with specialists, the very range of which allows for the provision of optimal medical service.

There has been relatively little recruitment of behavioral specialists for researching the special mental health problem (e.g., isolation, medically induced pain) of the children's ward. With the rapid development of the behavioral sciences, it is not an easy matter to know the various subspecialties within the field. The physician may not know to whom to turn, how to frame

his psychomedical problems, and what types of help he might expect. But we cannot neglect the observation that the motivation to solve social-psychomedical problems does not have the impetus of the attack on biomedical problems, and that it must be explained, in at least some small measure, by the impediments discussed in this paper.

Although the mental health professions are concerned, there is little doubt that the hospitalized child's psychological well-being will never be assured without the physician's active involvement with this problem. Reliance on an automatic infiltration and spreading of psychological knowledge and method into hospital practice is wishful thinking and unrealistic.

Psychological care means comprehensive and complex planning of the organization of the children's ward (and hospital) as a subsocial instrument—with all the problems which this entails—for purposes of psychomedical treatment of ill children. Although he may not be able to do this without help, this is the physician's job. No one is as qualified to do it as he, and no one can or is going to do it for him.

PSYCHOLOGICAL CARE HAS DISADVANTAGES

Advances in hospital organization and function generally are internally generated. However, when an advancing line of development impinges negatively on its members, we might expect resistance to this type of change. Psychological prophylaxis changes the working conditions of the children's ward in ways which conflict with staff preferences.

Psychological care necessitates that medical staff attune themselves to the emotional as well as the medical needs of each child. Medical action is subjected to constant consideration of emotional impact and the

possibility of emotional sequelae. Medical diagnosis and treatment become complicated by the need for more elaborate strategies. There can be no doubt that the professional demands on the staff are greatly increased. This is not invited when the psychological aspects of a case are only of peripheral interest, or when competence in this area is seen as adjunctive rather than as central to professional competence.

If psychological care is to be an intrinsic part of the work of the children's ward, it must have an investment of time and effort in its own right. How, otherwise, can children's emotional health be planned for and problems tackled? But with busy medical practice and tight schedules, the matter of staff convenience becomes an important consideration. Limiting concern to children's medical needs allows the staff to deal with more cases or to take on other things.

In raising these issues, one can expect a favored plea: "... give us more funds, more staff, better facilities. . . ." But part of obtaining additional funds is preplanning their use and selling the need for them.

Without professional planning and administrative support of psychological methods, new funds, staff, and facilities can be easily misused.

A fundamental mental health recommendation for protecting psychological well-being—that mothers of children from about 6 months to 3 or 4 years be present as much as is constructively possible during their child's stay in the hospital—does not require increased expenditures or new types of facilities. In spite of its advantages and successes, this method is greatly resisted. Why? Understanding this requires looking beyond superficial explanation into informal professional factors. What is not generally realized (verbalized) is that hav-

ing parents on the ward shifts the "power" balance between medical worker and public.

The prestige of exclusiveness is destroyed. The mother, as the child's natural protector, may pressure hurried workers into paying attention to the child's emotional dispositions and idiosyncracies. The parent will observe the medical staff in their weak as well as strong moments. Among other things, inefficiencies and mistakes which ordinarily go unnoticed become public. It can be seen that, without strong self-indoctrination regarding responsibility for the total well-being of the child, this type of partnership with parents for the care of their children can be easily experienced as professionally infringing and medically unproductive.

DEFENSIVE DEVALUATION OF BEHAVIORAL KNOWLEDGE

My observations lead me to believe that not infrequently the physician is in a kind of bind regarding the behavioral side of practice. Public and profession ascribe to him a role in which he assumes and exercises important mental health influences. For many parents, he is *the* behavioral expert.

However, as previously discussed, the physician often feels that he is in no position to take on behavioral responsibilities. He might consider that he is not fulfilling certain needs of his patients, or that, in a sense, he is misrepresenting himself. On the other hand, he feels he cannot relinquish the role of expert on childrearing and children's behavior without doing damage to himself and his profession.

There is danger here of certain pat solutions. One such possibility is a manifest, acknowledged retreat from behavioral responsibilities. Biomedical functions are

conceived of as sufficiently paramount, important and self-rewarding, with psychosocial factors considered removed from competence and concern.

One appealing solution is to devalue the importance of psychosocial factors for the child's future development (e.g., the faith that forgetting will always take care of the child's unpleasant psychosocial experiences, that behavior problems will be outgrown rather than submerged), meanwhile overstressing the importance of biological processes, a viewpoint congruent with the long-standing bias against psychiatry which still operates in some medical centers.

If psychological interaction is essentially unimportant for the child's development, then the body of child-psychological knowledge, however profound, need bear little relevance to active medical work. Lack of specific psychological information becomes untroubling; whatever one does or does not do regarding behavioral issues become happily devoid of unhappy consequences. The psychological unknown and problems faced in any pediatric practice become trifling within the total context of problems facing the physician.

It is possible to go a long way in ignoring mental health matters altogether, awaiting the day when all children's emotional difficulties will be treated simply by biochemical methods.

Adequate mustering of professional forces for the deficiencies of the hospital in psychological care become virtually impossible when the importance of the child's emotional and interpersonal experience for his future (and that of society) is avoided.

Devaluating the importance of psychological processes has other functions. In his hospital work the physician is far from oblivious of the child's emotional anguish. Quite the contrary, he senses the truth of

the ward's contribution to many a child's emotional condition. Now and then, through his work with an appealing patient or through experiences with his own child in the hospital, he is ruffled by this knowledge.

The scientifically awake physician is reminded and goaded by papers, talks and symposia which appear with greater and greater frequency. He wishes strongly to do something about hospital care of babies and children, and we find his support and utilization of the piecemeal innovations and changes that now characterize most wards. But the problem seems too big. No matter how routine, facilities, buildings and times change, he still must face that child whose unspoken language of face, movement and body arouse thoughts and feelings that are not easy to live with. Here, devaluation of the importance of the child's present experience in the hospital for his future development reflects personal wish and a defense against guilt.

SUMMARY

1. Disease-oriented management of sick children was discussed as functional within the context of earlier stages of institutional development and medical practice. Progress in the medical and psychological sciences, however, places considerable pressure on the pediatric ward to develop its organization and practice for enlightened mental health care of hospitalized children. Resistance to psychological prophylaxis was presented as a maturational crisis in sociomedical organization and practice.

2. Effective psychological methods require strong self-indocrination, leadership and the organization of the children's ward and hospital for this purpose. New types of knowledge and skill must be exercised along with self-limitation of traditional medical prerogative.

3. Basically, almost everyone agrees with the principles and goals of psychological prophylaxis, but serious developments are slow to come, because this type of care often conflicts with intellectual or professional proclivities and conveniences.

4. Psychological care is also handicapped

by an attitudinal syndrome devaluating the importance of psychological factors for the child's future development. When this is the case, there is difficulty in awakening the medical worker to a fully sensitive regard of psychological issues in hospitalization.

The California recovery house: A sanctuary for alcoholics

The vexing question of what is to be done about the nation's estimated five million alcoholics is especially prominent in California public life. One index of official public concern is the unprecedented 1964 budget of over \$1 million dollars for the Division of Alcoholic Rehabilitation of the State Department of Public Health. A lay response is the unheralded but stubborn advance of the alcoholic recovery house in the last decade.

Today, California recovery houses serve more than 4,000 residents a year at practically no cost to the public. There are now approximately 50 independent facilities throughout the state, and new houses are being founded by groups of interested

citizens. The houses have not formed a statewide federation, but their representatives have met to discuss mutual problems under the sponsorship of the Division of Alcoholic Rehabilitation, which has financially aided some houses, beginning in fiscal year 1961-1962, and has also published a study of the new movement.¹

Since movements normally develop to meet some felt public need, it is important to ask, what is new about the recovery house? Why has it become so prominent at this time? What functions are performed by these small private facilities that are not already performed by existing institutions?

ALCOHOLIC REHABILITATION: PUBLIC AND PRIVATE

The modern theme of "rehabilitation" is now quite fixed in the public mind. The past furor over "drunkenness" in America, called to mind by temperance crusades,

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¹ Martinson, Robert, *Residential Recovery Establishments for Alcoholics* (Berkeley: California State Department of Public Health, Division of Alcoholic Rehabilitation, April, 1963).

salvationism and prohibition, has long given way to large institutionalized efforts by state agencies, clinics, mental hospitals and sanitariums. Alcoholism has become a specialty of trained disciplines, a public health problem to be adjusted among a group of competing agencies rather than a moral problem to be confronted by exhortation, frenzied denunciation, or the pledge.

Nevertheless, the efforts of agencies, specialists, and state programs have apparently done little to substantially reduce the problem. Huge sums are spent annually on research and rehabilitation, yet the alcoholic problem remains, persistent and seemingly intractable. Under these circumstances, large numbers of alcoholics still regularly experience the humiliations and horrors of the drunk tank, the state mental hospital, the soup kitchen, and even the state prison. For them the revolving door continues to revolve, and "rehabilitation" is simply to hollow sound, perhaps to be interpreted as the official, ideological response of an essentially indifferent populace.

Historically, Alcoholics Anonymous has been the most powerful response to the defects and gaps in official rehabilitation efforts. AA organized the ex-alcoholic and gained public attention for his efforts to maintain sobriety and self-respect. But, like many mass organizations before it, AA has now come of age. Over the years it has tended to harden into a self-contained milieu with ritual trappings which give it the air of a religious sect. Too successful to ignore, it is now frequently criticized for these "cult-like" observances which have become a vital part of the weekly (sometimes daily) experience of more than 300,000 true believers throughout the nation and the world.

AA may not square with our own quite

modern faith in medical omniscience and the healing power of psychiatry, but it has no competitor as the dominant movement of salvation for the alcoholic. Led by persons of white-collar and professional origin, it combines the ancient remedy of brotherhood with the modern myth of Horatio Alger in a way which obviously appeals to large numbers of mid-Twentieth Century Americans. The new public health image of "The Problem Drinker"—neither stew bum nor wealthy ne'er-do-well, just the man down the street—symbolizes the parallel rise to medical respectability of this organized minority's newly discovered "disease"—alcoholism.

It would be an error to suppose that the California recovery house is simply an extension of Alcoholics Anonymous. (As an organization, AA neither supports nor sponsors any house.) Yet the influence of AA ideas and personnel is striking in most houses, even those officially sponsored by the Episcopal Church.

Without the prior formation and success of AA, the growth and spread of the alcoholic recovery house would be difficult to explain. Less dogmatic than AA, the houses potentially appeal to a much broader group. Yet despite this seemingly broad appeal, it is the main contention of this article that recovery house methods implicitly point toward the most radical method yet devised for a solution to the alcoholic problem in America: the voluntary social exile of the alcoholic.

In place of the *sober fellowship* of ex-alcoholics, which is the historic invention of AA, the recovery house introduces the principle of the *sober community of ex-alcoholics*.

HALFWAY HOUSE OR SANCTUARY?

The recovery house is often put in the same category as similar small facilities

(usually called "halfway houses") found in the areas of mental health, drug addiction and even correctional rehabilitation of parolees and juvenile delinquents. (All of these small facilities are similar in that they closely resemble an ordinary guest house or boarding house.)

One report describes the typical facility which it studied as:

"... a facility which bridges the gap between penal and other large institutions and the community. It makes the assumption that certain individuals can best be rehabilitated if their return to the community is gradual rather than abrupt. Its aim, starting with sobriety, is gradually to introduce the men to jobs, independence, and respectability in the community."²

This description lumps together establishments which might better be separated. It treats the recovery house (an estimated one-third of its sample) as fundamentally an extension of official rehabilitation efforts, as a new treatment method for bridging the "gap" between the correctional or custodial institution and the community.

However, the California houses do not typically recruit residents from correctional institutions but from the general run of problem drinkers in their own communities. They are private rather than public institutions, marginal enterprises founded and maintained by private citizens and operated independently of the complex of

state-supported and publicly sanctioned rehabilitation efforts.

They are not "pathway" or "transitional" facilities, and in contrast to the "halfway house" for mental patients (from which the name apparently derives), their residents typically move from the relative freedom of the community-at-large to the more restrictive environment of the recovery house; the mental patient, however, is normally transferred from a ward to a halfway house, thereby making the opposite kind of progress.

Perhaps in place of the word "sanctuary," one might use the word "retreat," which is defined by the *Shorter Oxford English Dictionary* as "a period of seclusion or retirement from one's ordinary occupations devoted to religious exercises." Both terms are metaphoric approximations intended to illustrate an important social attribute. Some information from the California study³ regarding these houses may help to clarify this distinction.

THE CALIFORNIA RECOVERY HOUSE

In the last decade, 35 to 40 recovery houses have been established in California.⁴ The 25 houses included in the California study are scattered throughout the urbanized areas of the state in or near the larger cities. They are converted private dwellings or boarding house type structures with bed capacities ranging from 6 to 75. Most of the women's houses are small, with 15 beds or less. The men's houses are larger and have a wider range of bed capacity; half of them have more than 20 beds.

Unlike missions, shelters, "drying-out joints," or flophouses, the recovery houses are not located in Skid Row areas or in outlying rural locations, as are many sanitariums. Only four houses are in commercial neighborhoods; the remainder are part of a residential area. Unlike the "halfway

² Blacker, Edward and David Kantor, "Half-way Houses for Problem Drinkers," *Federal Probation* (June, 1960).

³ *Op. cit.*

⁴ The only national survey, carried out in 1958, uncovered only "... 30 institutions which seemed to meet the required criteria for a halfway house" in the United States and Canada. *Halfway Houses for Alcoholics* (Boston, Mass.: Office of the Commissioner on Alcoholism, Massachusetts, November, 1958).

houses" for patients recovering from mental illness, they are not adjacent to hospitals or clinics. Like guest houses, the recovery houses blend in with their neighborhoods and are noninstitutional in appearance. Even some of the names—Friendly House, Harmony House, New House, El Portal, Casa Serena—express the image of a haven or retreat.

The houses are private, often nonprofit establishments founded, supported and maintained through the efforts of interested private citizens, ex-alcoholics and private philanthropic organizations. Each house is a unique local effort combining community resources, nonprofessional staff, the strong service motivation of the recovered alcoholic, and the desperate need of the "sick alcoholic" into an organization which maintains a permanent residential establishment.

THE CHARACTERISTICS OF RESIDENTS

The recovery house is not designed for public charity and the mission handout. In California, the houses are not focused on the "correctional" or "unreachable" alcoholic, or the "chronic drunkenness offender," the person who constantly shows up in drunk tanks, mental hospitals and custodial institutions. Those who have made a career of these kinds of experiences do not appear to form a majority of residents.

An analysis of 827 residents of New House, a Santa Barbara recovery house for men, for the five-year period 1955-1960, shows that, while far from affluent, residents are also not Skid Row derelicts. Socially they are a part of that group of problem drinkers who inhabit the middle layers of American life. Although there is a category of persons ("circuit riders") who attempt to exploit recovery houses by staying a short while, sobering

up or drying out and then leaving without paying their bill, they represent probably less than a quarter of recovery house residents.

House managers are usually able to select residents who will enable the houses to cover their necessary operating costs. Residents most often come from the local community. They may refer themselves to the house or be referred by police authorities, alcoholic outpatient clinics, hospitals and sanitariums, AA acquaintances, friends and relatives. In some cases, residents may be unofficially released to the house by a judge who wishes to give a likely prospect a chance at recovery and future rehabilitation in a nonpunitive environment.

Thus the residents are involved in an organized effort at self-help. If the houses were not available, residents would be forced to fall back on their private resources, aid from families and friends, or help from alcoholic clinics, state mental hospitals and other facilities.

In every house included in the survey residents were expected to pay for or contribute to the costs of their upkeep. Even in those few houses which solicited a "donation" in place of a fee, residents were expected to pay, if financially able. The house fee, regarded as a payment for room and board, was well within the budget of an employed resident. Half the houses reported charging fees in the \$20-\$24 per week range, with a median figure for all houses of \$20.50 per week.

Although no house required that an applicant be working at the time of entry, half reported that ability to work was a formal requirement for admission. Many of the houses placed considerable emphasis on work as a means of rehabilitation and encouraged residents to seek jobs while living in the house.

In addition to residence fees the houses depended upon donations made by former residents, friends, philanthropic organizations, the community chest, and civic organizations. These were supplemented by income from charter memberships, a restaurant and even bingo games.

Only three houses depended to any extent upon income from welfare payments. Welfare payments constituted 75 per cent of the annual income of one men's house, and 30 per cent and 5 per cent of the annual income of each of two women's houses.

THE HOUSE COMMUNITY

Recovery house living is voluntary; residents are recruited, not committed. If residents are not held in a recovery house by legal coercion, what prevents them from drinking?

Recovery house managers insist that an applicant must be "sincere" in his desire to stop drinking when he comes to the house or he cannot be helped. Managers make an effort during their first interviews with applicants to draw them out in order to judge this "sincerity." Through this process some of the least likely candidates can be screened out at the beginning.

Although residents are not treated as patients or inmates, they are expected to observe some elementary house rules. The rule which is most common and most vigorously enforced relates to drinking on or off the premises and bringing liquor into the house. This was cause for dismissal in every recovery house. This matter is so crucial that some houses will also dismiss anyone who shields a resident who is drinking.

The new resident has already been removed from easy access to previous environments by simply becoming a resident. Further, most houses have special regula-

tions and orientation for him. He may be asked not to leave the house at all for some period of time, ordinarily a week. After this trial period he may be permitted to leave the house temporarily, usually after requesting permission, and sometimes only if accompanied by another resident.

A resident is expected to do much more than merely obey the rules, as few as these are. As he adjusts to recovery house living, he is expected to take on more responsibility both for the house and for himself. Each resident is expected to help keep his own quarters clean and in order, and, in addition, he may be expected to do a minimum of house chores. Many houses provided employment for residents, such as cooking, dishwashing, helping in the kitchen, maintenance work and clerical duties.

About half the houses required that a resident be employed after a suitable period, although one women's house did not permit outside employment because of an extensive therapy program. In general a resident is expected to take advantage of the opportunity provided by the house and staff and to co-operate actively in his own recovery.

Finally, an attempt is made to incorporate the resident into a social group composed of staff and other residents. This process is aided by "old-timers" who perform the function of senior advisers or counselors for the house. As would be expected of any voluntary organization, the desire to gain the respect of staff and other residents should be an increasing factor with length of stay.

Almost nothing is known about the characteristics of the house community. This is probably the richest area for future investigation, and premature use of terms like "therapeutic milieu" simply begs the question. Behind terms like "fellowship,"

"supportive," "homelike," and so forth, there is an intricate set of relations involving some of the more complex types of fellow humans.

Since the houses continue to make trial and error changes in staff, program and procedure, it is certainly much too soon to come to set conclusions on their value as "rehabilitation" centers, although their ability to maintain the sobriety of their guests during residence can hardly be disputed.

SOBER COMMUNITIES?

House managers do not propose a total withdrawal from this world. Residence is temporary in theory (three months being an often proposed period of time), and for many residents the stay in a recovery house may be an unimportant and soon-forgotten incident. Residents are urged to seek work in the community, and work itself is normally regarded as rehabilitative in effect.

Hence, there is nothing monkish or utopian about these houses. Nevertheless, healing is presumed to take place *within the context of house life*, and the house is a segregated and exclusive residential center for a very special kind of sober community. It is not a community of "abstainers," but one of ex-problem drinkers. Even house staff are normally ex-alcoholics who have decided to spend their lives in a new lay profession as aides, counselors or advisers to persons seeking to recover from alcohol addiction or overuse.

The resident (typically called a "guest") does not simply reside in the house; he is expected to become part of an ongoing set of activities centering in the house and relatively isolated from the influences of his previous environment whether family, neighborhood, work associates or drinking pals. He is offered a substitute for normal family life, membership in a voluntary

community of ex-drinkers who, like himself, have experienced the life problems which usually face the alcoholic.

Recuperation and recovery in such an environment may seem quite problematic (despite the initial advantage of enforced sobriety), yet to the sick alcoholic the only other available kinds of sober "communities" are to be found in drunk tanks, county farms, prisons, asylums and other closed institutional systems.

Of course, "abstainers" have not altogether disappeared in America, but they are now a statistical category interspersed in the population at large and they do not form communities of their own. For many alcoholics involvement in AA meetings is sufficient partially to isolate them from contacts with normal drinking customs. The recovery house carries this process a step further by reinforcing the impact of "the program" through residential segregation.

Recovery house managers and official policy both regard house residence as a temporary "therapeutic" measure rather than as a "way of life," and it would be an error to describe this movement as a modern urbanized variant of nineteenth century utopian colonization schemes. Surely there are good practical reasons for temporarily isolating the problem drinker from an everyday environment which constantly tempts him to take that "first drink," either through the subtle pressures of the face-to-face group or the blatant blandishments of the mass media.

This must be an especially powerful motivation if the problem drinker has incorporated the self-image of the "alcoholic," the person forever removed from the common-run by his inability to ingest even the most moderate amount of beverage alcohol. To be an "alcoholic" is to be a particular kind of person in a society where

alcoholism is either a "disease" (public health), or a kind of "fate" (Alcoholics Anonymous).

The recovery house can provide a home base to this person—a temporary sanctuary from socially approved drinking practices while he takes the first steps toward recovery and, hopefully, later returns to the community from which he has withdrawn. There is nothing bizarre here. All of us live to some extent in specialized environments determined by our occupation, station, neighborhood, region, ethnic or religious affiliation, and a temporary community of dry drunks is surely no less defensible than a vacationland of social nudists or any other of the innumerable "single-issue" subgroups in American life. The recovery house is both practical and visionary and should be regarded as a social experiment in new patterns of living for a particular subgroup in American life.

A COMMUNITY ENTERPRISE

For society as a whole the recovery house movement is much more than a new minority group way of life. The social costs of maintaining the alcoholic minority are enormous, especially with the essentially punitive methods now commonly in use. When these social costs are compared with the "cost" of maintaining these recovery houses, the social advantage is quite apparent.

The houses are economically marginal enterprises, neither profit-making in their

aim nor profitable in actual operation. They are normally incorporated as non-profit corporations and are governed by boards of directors composed of prominent civic leaders and other interested persons. In 1961, for the two-thirds of the houses reporting, annual operating costs amounted to more than \$300,000. The total "cost" in 1963 of all "recovery establishments" listed in the California directory might approach \$800,000 a year, a figure which approximates the public health budget for alcoholism in the state.

Very little of this amount can be regarded as a true cost to society. As private organizations which provide a way of life to their participants, the houses are essentially self-supporting, although they depend to some extent upon the philanthropic aid of local groups and organizations. They offer the interested citizen a way of directly influencing the alcoholic population in his own community, but they also depend to a decisive extent upon the alcoholic himself; he must collaborate in this joint venture by paying weekly fees for room and board, and by contributing work and services to the house.

The recovery house may not be a magic solution to the alcoholic problem, but it is a practical and immediate step open to almost any American community. Any local group can establish a recovery house in its community by modifying an existing boarding house or guest home, finding a manager who has had some experience with alcoholics, and opening the front door.

HERBERT A. OTTO, Ph.D.

The personal and family strength research projects: Some implications for the therapist

This paper will describe some of the findings and outcomes of a series of research projects in an area which has received scant attention—the area of personal and family strengths and human potentialities.

Implications of these findings for the therapist, caseworker or clinician will be discussed. The research projects entitled "The Personal Resource Development Project" and "The Family Resource Development Program" had their beginnings in 1959 and 1960 at the University of Georgia. At that time, some of the theoretical and methodological framework was developed with the support of the Community Mental Health Services, Division of Mental Health, Georgia Department of Public Health. The basically preventive and experimental focus of the Mental Health in Education program at the University of Georgia¹ also contributed to the development of theory.

Finally, the theoretical background of

this work is based, in part, on the formulations of Gardner Murphy, Abraham Maslow's extension of Goldstein's concept of self-actualization and Erich Fromm's thinking about human potentialities.²

Over the past two and one-half years, the research program has been continued at the Graduate School of Social Work of the University of Utah. The two research

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¹ Otto, Herbert A., "Developing a Mental Health Program in a Teacher Training Institution," *Mental Hygiene* 44(April, 1960), 188-96, and Otto, Herbert A., "Spontaneity Training With Teachers," *Group Psychotherapy* 15(March, 1962), 74-80.

² Murphy, Gardner, *Human Potentialities* (New York: Basic Books, Inc., 1961). Maslow, Abraham H., *Motivation and Personality* (New York: Harper and Bros., 1954); and Fromm, Erich, *Man For Himself* (New York: Holt, Reinhart, and Winston Inc., 1960).

projects have been described in detail elsewhere.³ To date, 16 experimental groups have been conducted. Two of these groups were composed of students at the Graduate School of Social Work and three were family groups (from six to eight couples each). The remaining groups consisted of 11 extension classes conducted under the direction of the writer and offered by the University of Utah Extension Division as a noncredited course entitled "Developing Your Personal Resources." This class is described in the Extension Division Catalogue as follows:

"This program is designed to help you to discover capacities, strengths, talents and abilities which you have but which you may not be aware of or using fully. Emphasis is on discovering your potentialities and developing them, leading to more vital, creative, satisfying living and productivity."

It should be noted that to date all research has been conducted with so-called "healthy" or nonpatient groups. However, in view of the Cole study,⁴ and similar reports, as well as the recently released Manhattan study,⁵ there is evidence that the major difference between patients actively seeking help from professional sources and the general population is that the patient

group has taken the step to actively seek help.

The writer's observation and experience, extending over 12 years of practice and including extensive work with so-called "healthy" groups, emphatically confirms these findings.

Methodological aspects of the Personal and Family Strength Research have been described in detail in professional journals.⁶ This research is essentially in the area of individual and family strengths and human potentialities and is based on the assumption that the average well-functioning individual is operating at 15 to 20 per cent of his potential.

The basic purpose of this research was to investigate the following:

1. What do we mean by family strengths?
2. What are personal strengths?
3. What means and methods can be discovered which will help individuals and families to utilize a greater portion of their strengths and potentialities—their unused or latent capacities, resources, talents and abilities?
4. Closely related to the above, what methods can be developed, designed to maximize ego strengths?

A small group approach was utilized as an integral part of the Personal and Family Resource Development Research Projects. Groups were usually limited to 17 members or fewer. The combined thinking and support of the group was used as a means of helping group members develop and make better use of their strengths and potentialities.

The emphasis was on "Action Programs," or using strengths at home, on the job, or in other concrete ways, other than talking about them. Members periodically reported their action programs to the group and asked the assistance of the group in

³ Otto, Herbert A., "What is a Strong Family?" *Marriage and Family Living*, journal of the National Council on Family Relations, 1(1962) 77-81.
 Otto, Herbert A., "The Personal and Family Resource Development Programs—A Preliminary Report," *The International Journal Of Social Psychiatry*, 3(Summer, 1962), 185-95.

⁴ Cole, Nyla, et al., "Mental Illness—A Survey Assessment of Community Rates," *A.M.A. Archives of Neurology and Psychiatry* 4(April, 1957), 393-398.

⁵ Srole, Leo, et al., *Mental Health in the Metropolis* (New York: McGraw-Hill Book Co., Inc., 1962).

⁶ Otto, Herbert A., op. cit., and Herbert A. Otto, and Kenneth A. Griffiths, "A New Approach to Developing the Student's Strengths," *Social Casework*, 3(March, 1963), 119-24.

overcoming blocks and difficulties encountered in the course of carrying out "Action Programs."

Every effort was made to establish a type of group atmosphere where communication in depth was possible. The focus of the interpersonal exchange throughout the group experience was essentially on the participants' strengths and potentialities, with problem and pathology-centered material being dealt with as it was brought out. Although the discussion of personal problems was not discouraged, a very minor amount of time was devoted to this subject, and the majority of the interpersonal communications centered on the process of defining and "actualizing" personal strengths and resources.

Analysis of data from the research projects has progressed to the point where a number of findings of significance to the therapist can be presented. A second paper is in preparation which will consider the findings from the Family Resource Development Research Project and their implications for the therapist interested in family treatment or family group therapy programs.

THE DEVELOPMENT OF A BASIC VIEWPOINT

If the hypothesis that the so-called average healthy human being is operating at 15 to 20 per cent of his potential is accepted, then the task of "actualizing" his potential can become the *raison d'être* or motivating life purpose of the individual or practitioner who makes this choice. A considerable segment of the educated populace, as well as many professionals, would probably see themselves as committed to this point of view and as being engaged in a number of efforts to actualize their potential.

However, in the vast majority of in-

stances, this represents a post-facto rationalization, or an attempt to fit certain patterns of activity within the framework of "actualizing one's potentialities."

From this writer's viewpoint, we can speak of an integration or an internalization of this viewpoint *only when the major and conscious life focus of the individual is directed toward translating his potential into action. This means that every possible conscious (and unconscious) effort is bent in this direction, and that the basic life pattern is one of consistently seeking experiences and deep interpersonal relationships, with the conscious aim of searching out and actualizing potentialities.*

Implicit is a total commitment where all goals, drives, values and aspirations of the individual are placed in a subsidiary or supportive role to this major aim. (Realistically speaking, this is a very difficult task made almost insuperable by our contemporary culture, which is overwhelmingly pathology-centered and which surrounds the individual with pathological vectors.⁷)

Dunn's concept of high-level wellness similarly focuses on "actualizing" the human potential. Kaufmann, in a recent article, points out the following:

"A high-level wellness for the individual, as defined by Dr. Dunn, is: An integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the environment where he is functioning.

"It therefore involves: (A) direction in progress forward and upward toward a higher potential of functioning, (B) an open-ended and ever-expanding tomorrow with its challenge to live at a fuller potential, and (C) the integration of the whole being of the total individual—his body, mind, and spirit—in the functioning process."⁸

⁷ Of interest in Kubie's article, "Social Forces and the Neurotic Process" in Leighton, Alexander H., et al., *Explorations in Social Psychiatry* (New York: Basic Books Inc., 1957) 77-104.

⁸ Kaufmann, Margaret, "High-level Wellness, a

The basic viewpoint delineated by the writer in the previous paragraphs has a number of implications for the therapist. If a therapist subscribes to the point of view that man's primary goal should be the actualizing of his potential, then this becomes the major operational bond between the therapist and patient.

Consequently, *the goal of therapy* is not to help the patient work through his emotional pathology nor to facilitate his social adaptation, but to *assist him to discover and make maximum use of his potentialities—the range of his strengths, capacities, and capabilities*. At the same time, "working with" and "working through" pathology and the delimiting of intrapsychic conflict is an essential concomitant of the basic focus on individual strength and potentialities.

Therapist and patient are seen as engrossed in a most difficult undertaking. Not only is it the practitioner's task or function to encourage and assist the patient in utilizing his potential, but the patient has a similar task, function, and responsibility. (We already recognize that not only does the therapist give to the patient, but the patient also gives deeply to the therapist.)

The identification, utilization, and development of individual strengths and potentialities then becomes the basic and underlying element of the interpersonal exchange. With this fundamental attitude or viewpoint in common, both therapist and patient bend every effort to create an atmosphere where mutual confrontation, "emotional honesty" and a sharing of basic goals and concerns (the meaning of existence) become tools in an interaction process aimed at the development of potentialities

by two individuals who have come together for this task.

THE EMERGENCE OF A CONCEPTUAL FRAME OF REFERENCE OF PERSONAL AND FAMILY STRENGTHS

A tremendous amount of effort plus staggering sums of money have been spent on the study, detection, and treatment of emotional illness. On the other hand, although the professions of psychiatry, social work and psychology utilize the concept of individual and family strengths, closer examination reveals there is no clearcut recognition as to what precisely constitutes strengths.

Research in this area is minimal and to the writer's best knowledge, the efforts at the University of Utah constitute the first attempt to develop a theoretical construct of personal and family strengths based on research. A beginning frame of reference of personal and family strengths has been developed. However, this is an initial effort and much more research must be done before a definitive characterization of strengths can be expected to emerge.

It is recognized that it is a paradox of strength conceptualizations and frameworks that any so-called strengths may, as a result of intrapersonal or exogenous factors, become an impediment, act as a locus of problems, and consequently can be seen as a "weakness." However, a similar paradox exists in relation to pathological syndromes and manifestations so that obsessive compulsive behavior in certain highly structured environments is viewed as a very healthy and commendable activity.

RESISTANCE TO STRENGTHS AND POTENTIALITIES

It is one of the findings of this research that the average healthy individual has con-

siderable difficulty listing his personal strengths. An individual with some college training will usually list four to six strengths. This phenomenon is examined in a paper entitled "Self-Perception of Personality Strengths by Four Discrete Groups."⁹

If the same individual is asked to list his problems or weaknesses, he is usually able to write prolifically and compiles lengthy lists. Usually, the lack of ability to list strengths has been rationalized by participants in the experimental groups as being of "cultural origin." For example, group members have said: "When I write down my strengths, this is like bragging about yourself, and this is something that just isn't done."

Although cultural elements are in the picture, there are strong indications that this marked resistance to the development and utilization of strengths is anchored in a very deep-seated and powerful "fear-guilt-anxiety cycle." The individual *fears* to develop his strengths, as this would mean both exercising leadership, "sticking his neck out," and, more fundamentally, it would demand personality change and change in his basic habit and behavior patterns.

Intimately linked with this fear is a deep sense of *guilt*. This guilt stems from the (often partially conscious) recognition that there are specific resources, strengths, and capacities which the individual *deeply knows are present as latent forces*, which, however, he does not utilize, leaving him with a sense of "lack of wholeness" or unfulfillment, which is experienced as a psychic self-crippling.

This self-crippling, stemming from lack of developing personal potential, generates a pervasive guilt which, in turn, is repressed. *Anxiety*, the third element, is seen as both flowing from this vicious cycle as

well as contributing to it. Considerable psychic energy is bound up or invested in this process. If this energy can be freed or redirected to more productive purposes, the total personality may move markedly in the direction of optimal functioning.

In turn, closely related to this fear-guilt-anxiety cycle are three basic core configurations. It is our hypothesis that unless these core configurations are investigated in depth, the major portion of an individual's potential must, of necessity, remain in *status nascendi*. These core configurations relate to the individual's basic attitudes and feelings toward sex membership, death, and his value structure.

For example, in relation to sex membership, such questions as the following need to be explored: "What does it mean to be a man or a woman? What would it feel like to be a member of the opposite sex? What are your basic feelings about sexuality and sexual relations?"

In relation to death, these areas should be investigated: "What to you is the meaning of existence and life? What are your real feelings about death and the inevitability of death? What is the relationship of these feelings to strengths and potentialities?"

In turn, the foregoing needs to be directly related to the value structure of the individual so that some of the following can be explored: "What do you really believe? What is your basic or 'bedrock' value structure, and what do you feel about these beliefs?" "To what extent are your basic beliefs related to your actions or functioning, and how does this make you feel? What is the relationship of the foregoing to your strengths and potentialities?"

It should be noted that for specific rea-

⁹ Otto, Herbert A., "Self-Perception of Personality Strengths by Four Discrete Groups," *Journal of Human Relations*, 12(August, 1965), 525-31.

sons none of the experimental groups to date have explored all of these areas in depth, although a number of segmental investigations have been undertaken. The main difficulty here has been in relation to three factors: time, community relations and lack of psychiatric consultation. Experimental groups have met on the average of once a week for two hours extending over a three-month period, based on the quarter system at the University of Utah. These limited number of meetings have been a contributing factor in militating against any exploration in depth.

It is also axiomatic that a pioneering and experimental venture needs to maintain good community relations in order to survive. Any deeper exploration of these areas would, of necessity, have resulted in a measure of disturbance in some members of the groups. It is in the high order of probability that as a result of such disturbances and possible community repercussions, the experimental class would have had to be discontinued. I may add that we fully intend to work with these areas under more propitious circumstances and when funds for adequate psychiatric consultation become available.

THE MULTIPLE STRENGTH PERCEPTION METHOD

The Multiple Strength Perception Method was developed during the first experimental student groups.¹⁰ The group leaders noted that beginning with the third meeting, participants increasingly pointed to strengths in each other. Since this type of interaction continued to persist for periods of time, it suggested to the group leaders that this process could be utilized construc-

tively to further the purposes and goals of the group.

The following method or procedure was, therefore, developed; a group member volunteers to be the "target person." This person then begins the process by enumerating and sharing with participants what he considers to be his strengths. After he has completed listing his strengths, the target person must then ask the group in the following or similar words: "What other strengths or potentialities do you see me as having, and what factors or problems do you see keeping me from using these strengths?"

Following this, all group members share with the target person what they perceive as being his strengths. This is done in an informal manner with all group members contributing their perceptions of the strengths of the individual who has volunteered to be the focus for this process. Group members variously called this method "bombardment," "being on the hot seat," or "being the goat."

It should be noted, however, that use of the M.S.P. Method involves more than a sensitive and empathic perception and listing of strengths. *Prior to the use of the method, the group works through and recognizes that the facing of problems or unrecognized aspects of self is an essential prerequisite for helping a person to identify and develop strengths and potentialities. The group also faces the fact that sometimes a seeming strength may actually be symptomatic of a problem or create an impediment to the optimum functioning of the personality.*

Group members, therefore, also feel free to contribute their perception of personality factors which they see as keeping an individual from utilizing certain strengths or resources. However, the focus is strength-centered in that participants con-

¹⁰ Otto, Herbert A., "Personal Resource Development Research—the Multiple Strength Perception Effect," *Proceedings of the Utah Academy of Science, Arts, and Letters* (1961-62) 182-86.

sciously attempt to use these insights as a means of helping the target person to make a fuller use of his potentialities.

For all group participants, the use of the Multiple Strength Perception Method resulted in a deeply personal, emotionally significant experience. It was evident from remarks and behavior that being the target person was a deeply meaningful experience for group members. Such remarks as the following were common: "It really shakes you up to have these things come at you from all sides," and "I don't know why it should make me sweat to have all of you point out these strengths, most of which I already know I have."

It was also apparent that the process of sharing their perception of the strengths of the target person was an emotionally meaningful experience for participating group members. A considerable number of group members voiced the following or similar feelings: "It makes me feel good to search out strengths and potentialities in others," and "To look for strengths in someone else makes me more aware of my own strengths."

Use of the Multiple Strength Perception Method over a period of two-and-one-half years resulted in a number of conclusions and findings:

1. Within a comparatively short period of time, the average healthy or normal individual is able to develop significantly increased sensitivity or perceptivity of strengths, resources or potentialities in other persons. For example, it became evident during the first experimental groups that group participants used a wide range of nonverbal clues. Remarks such as, "I noticed your voice changed when you said this during our last meeting," and "There was a sparkle in your eye when you talked about this three sessions ago" were frequent.

It has for years been a byword in clinical circles that the more severely emotionally disturbed or psychotic the individual, the more sensitive is he to emotional pathology in the therapist or others. This research indicates the corollary; namely, *the more healthy an individual, the more able is he to develop a perceptiveness and sensitivity for strengths, resources, and potentialities in others.*

2. Use of the M.S.P. Method appears to be related to changes in the productivity and professional functioning of the participants. For example, businessmen reported increased productivity and increased use of creative thinking.

A persistent pattern was evident which can be summarized by the remarks of one businessman: "I find that I suddenly have the energy to do things that I have put off for months and years. Most of these are things that seem to make an extra emotional demand on you, and it is like taking that extra step which you know you ought to take but never quite get around to doing. It is a nagging sort of feeling, and you don't know what a relief it is to finally do these things which you have put off."

Examples of changes in professional functioning were reported by graduate students of the School of Social Work. They noted that in their agencies and in the course of the casework treatment process, they began to place greatly increased emphasis on the strengths and potentialities of clients, and that the clients responded positively to this.

These group members also reported that relations with colleagues and fellow students improved as they began to recognize strengths and potentialities in their associates.

3. Use of the M.S.P. Method seems to have contributed to a strengthening or enhancing of the self-image of participants. Group members reported feeling "more

capable," "more competent," "more ready to try out new ideas or activities," and more able to relax and enjoy themselves after work. Group members also pointed out that prior to this experience they did not have a clear idea of the range of their strengths and potentialities, whereas they had a fairly good grasp of their weaknesses and problems.

They stated that use of the Method had contributed to a clearer understanding of the "topography of their strengths" leading to a more realistic self-appraisal. This was evident from recurrent statements of the following or similar nature: "This has given me a much more balanced picture of myself," and "I am much clearer about my personality assets and liabilities; this helps me select goals I can achieve and stick to them because I know I have the resources to carry through."

Only recently a significant addition to the method was developed. The group interaction around the target person usually lasts between 30 minutes to an hour. At the conclusion of the process when group participants were unable to perceive any further strengths and potentialities in the target person, the group leader makes the following suggestion, "Now that we have seen the range of strengths and potentialities in John (or Mary), what sort of fantasy or dream do we have about John (or Mary), if he uses all these strengths? How would we see him (or her) functioning 5 years from now if he used all of these strengths and potentialities?"

The group then shares their fantasies and dreams about the target person.

Finally, the target person is asked to share his dream or fantasy about himself with the group. The following question is used: "What is your dream or fantasy about yourself if you used your strengths and potentialities and if circumstances were

such that you could do anything you wanted to?"

It is one of our findings that the shared group fantasy often shows a surprising correspondence with the deepest wish-dreams of the individual. The fantasies of the group coincide in most instances with 60 per cent or more with some of the deepest dreams and wishes the target person has about himself. This is a profoundly ego-supportive and ego-building experience for the target person as evidenced by the following or similar remarks: "You don't know what it means to me that you can see these things in me which I have dreamed and wished I could do all my life. It means that what I have dreamed and wished I could do, others see in me and I *can* accomplish them."

The Multiple Strength Perception Method can make a valuable contribution to a variety of group psychotherapeutic, group work or group counseling programs. Use of the Method is indicated when a group has reached the approximate midpoint of its projected life-span and after sufficient pathology and hostility have been worked through to allow efficient use of this technique.

USE OF ACTION PROGRAMS

During the first group meeting it is pointed out that "this is not a talking group, but an action group." It is stressed that increased utilization of strengths and resources can not take place solely as a result of one group meeting a week, regardless of the depth of interpersonal exchange or experience which takes place. A "motivational instrument," the Personal Resource Development Inventory, designed to stimulate and encourage participants to initiate Action Programs, is used throughout the group experience. Group members are

urged to become involved immediately in "Action Programs."

Action Programs are defined as any activity, program or interpersonal experience which the participant engages in outside of the group in order to facilitate the development of strengths or utilization of his potential. Group members are asked to use their best judgment in selecting that Action Program "which would do most for them."

Successes or failures with Action Programs are then reported back to the group by the individual members and evaluation of these programs is constantly undertaken to determine to what extent the individual is helped to develop strengths and encouraged to use potentialities. Where blocks and difficulties in sustaining Action Programs are encountered, the group member is urged to ask the assistance of the total group who then bring their sensitivity and perceptivity to bear in an effort to help the individual reach an increased understanding of his difficulty and to help him to remove the obstacle.

Although Action Programs initially are in most instances of a superficial nature (for example, arts and crafts activities or reading programs in specific areas), the tendency is toward progressively deeper involvement so that Action Programs are selected such as "having more meaningful relationships with friends" and "developing imaginative and creative resources."

The concept of Action Programs has direct application to the range of therapy, counseling and rehabilitative programs. Action Programs focusing on the strengths and potentialities of patients can be used as an effective "bridge" between therapy sessions. In a very real sense, the therapeutic process is extended into the process of living as the patient utilizes not only action programs but "total environmental

push" as means of making therapeutic gains. Currently, the sophisticated practitioner recognizes that much of therapeutic value occurs in the patient's life experience outside of the therapist's office, and the concept "life is therapy" has received wide recognition. However, little use is made of the principle of extending the process of therapy outside of the office door. *Through selective use of health vectors present in the patient's interpersonal and physical environment, the therapist can facilitate the patient's recovery and foster therapeutic gains.*

THE SUPPORTIVE ENVIRONMENT APPROACH

Use of any and all aspects of the participant's interpersonal relationships and physical environment in a "total environment push" has been one of the contributions of this research. It has been our observation that in those instances where group members used a number of facets of their environment in a supportive role in relation to the development of strengths and actualizing potential, they seem to have made more rapid progress. Generally, the more aspects of the environment used in a supportive role, the more sustained the progress experienced.

The use of "supportive environment" is by no means new. Murphy and Cattell,¹¹ discussing Sullivan's relation to field theory mentioned "... Sullivan's conception of the rebuilding of the patient's world is a first step in interpersonal theory."

Existential analyst Ludwig Binswanger points out that man is not a detached ego but a *being-in-the world*. He emphasizes the dynamic process character of this *being*

¹¹ Murphy, Gardner and Elizabeth Cattell, "Sullivan and Field Theory," *The Contributions of Harry Stack Sullivan* (New York: Hermitage House, 1952), 167.

which is necessarily in relation to the world. Binswanger and the existential analysts see the world with which every man is polarized as threefold: The *Umwelt* consisting of our biological and physical foundations, the *Mitwelt* of man's social and interpersonal relations, and the *Eigenwelt* of one's inner life and self-consciousness; i.e., the basis on which one orients to reality. Binswanger stresses that all three realms of relation must be taken into account if there is to be adequate therapy or treatment and that it is an error to emphasize one realm to the exclusion of the other two.¹²

Alexander, referring to a number of therapeutic studies of the Chicago Institute for Psychoanalysis, summarizes a series of technical recommendations resulting from these studies:

"... The essence of them is that, from the beginning, the therapist must be aware of the danger inherent in the regressive tendencies of the patients. To counteract this danger, the analyst must consistently give the patient as much independence as possible. Interpretations alone cannot accomplish this. The dependent tendencies can often be counteracted by reducing the contact with the patient to that minimum which is necessary to preserve the continuity of the treatment. Properly timed reduction of the frequency of the interviews, shorter and longer interruptions are indispensable in every case. *"Encouraging the patient to new life-experiences outside the treatment suitable to increase self-confidence and encourage hope are also potent devices in weaning the patient from dependence on the therapist."*¹³ [Italics added].

However, comparatively little use seems to be made by the majority of therapists

of the many environmental vectors which could be employed as supportive measures and therapeutic adjuncts. *Ignoring the principle that the supportive environment can become an important adjunct in the therapeutic and treatment process constitutes one of the vast wastelands of therapy.*

Members of the experimental groups are acquainted with the principle of "total environmental push" during the first or second session. They are told that the task of actualizing potential is a difficult one and that the more aspects of their environment they can enlist to aid in this process the better. The range of environmental aids is briefly presented in lecture form and discussed. The choice and initiative as to the use of "environmental push" is then left entirely a matter of individual decision by group participants. The following facets of "total environmental push" are presented:

1. *Analysis and Restructuring of Living Space*

The living space of the participants can be analyzed by him from a number of perspectives. For example, what sort of feelings does the furniture arrangement, color combinations and interior decoration give to the group member? Can living space be analyzed in terms of the needs of the group member or the family? Can furniture or interior decoration be changed in such a way as to give a greater feeling of freedom, lightness, airiness, space, or, conversely, hominess or snugness?

The rationale here is that the home environment can serve to maintain and reinforce the participant's focus on personal growth and the aims and purposes of the group experience, which thereby is *extended into the life experience of the patient*. Often a group member was able to

¹² Binswanger, L. quoted in May, Rollo, ed., "The Existential Approach," *American Handbook of Psychiatry* (New York: Basic Books Inc., 1959), 1,355-56.

¹³ Alexander, Franz, "Development of the Fundamental Concepts of Psychoanalysis," in Alexander, Franz and Helen Ross, eds., *Dynamic Psychiatry* (Chicago: University of Chicago Press, 1952), 34.

"restructure" only one room such as a bedroom. However, participants reported that every time the room was used, "It reminds me of the group and what I am working on."

2. *Analysis and Use of Significant Symbols*

It is suggested that group members may be interested in identifying "significant symbols" in their home and examining the effect of these symbols on themselves. What keepsakes, paintings or photographs are there to which the participant has emotional linkages? What is the meaning of these symbolic objects and how do they make the participant feel? From this viewpoint, does the photograph of father, mother, or aunt really belong on the mantelpiece? What does the symbol have to do with strengths and potentialities in the participant? On the other hand, can paintings, sculpture, keepsakes or other symbolic objects be used in a supportive way to focus attention on the task of developing strengths and actualizing potentialities?

3. *Use of Diet and Food*

It is pointed out that a diet can be used, tailored to the individual needs of the group member. Such a diet may be a reducing diet or one designed to assist in the gaining of weight. It may also be a so-called high-energy diet. The use of food in relation to energy, fatigue and physical strength and the symbolic use of food is discussed. It is pointed out that through diet and other uses of food, group members can have a very satisfying experience three times daily which, at the same time reinforces and helps them to focus on the objective and goals of personal growth.

4. *Use of Personal Restyling*

It is suggested that group participants

may be interested in examining the use of facial makeup, clothing styles and color combinations as well as hair styles as a means of contributing to a more positive self-image and to maintain the strength focus. Use of a highly trained beautician with a special interest in people is recommended. Similarly, men are asked to examine their use of wearing apparel, haircut and style of eyeglasses.

5. *Interpersonal Relations as a Source of Support*

It is pointed out that "we grew into what we are through interpersonal relations and we grow into what we can be through interpersonal relations." The statement is made that the complex web of interpersonal relations in which we find ourselves can be subjected to an analysis by asking the question: "Which relationships are experienced as especially supportive or strengthening?" Since certain relationships are experienced as strengthening, then other relationships may be experienced as unhealthy and tending to weaken or restimulating pathological areas in the group member. The question is then raised: "Can interpersonal relationships be deliberately sustained with the idea of seeking primarily those associations which are experienced as strengthening and which will help you in your efforts to actualize your potential?"

6. *Physical Exercise as a Supportive Measure*

It is pointed out that the development of strengths and potentialities must include physical as well as emotional and attitudinal aspects. Participants are urged to examine their current use of physical exercise and their health status. A physical examination is suggested when indicated. The question is raised whether a regime of physical exercises is of importance in the

development of personality strengths and resources. In this connection, the relationship of physical exercise to emotional states is discussed ("exercise makes you feel good") and the effect of physical exercise on the self-image is briefly explored.

It is the writer's conclusion that if a regime of physical exercises which have symbolic and emotional significance to the individual is linked with the group experience, considerably accelerated progress in utilizing strengths and actualizing potentialities can be achieved.

For example, preceding or following group sessions, participants should be able to swim in a heated pool, have an opportunity for massage and steam baths and be able to exercise or dance (interpretive, folk or social dancing) in a gymnasium type facility. Currently, therapeutic and counseling programs are characterized by their lack of utilizing such regimes, which can have definite ego-supportive values, and which can also have a profound effect on the patient's self-image.

CONCLUDING OBSERVATIONS

The findings and implications of this study are based on an experimental investigation in an area which has been considerably neglected by researchers. Although over the past years an increase is noted in the

number of research projects concerned with the study of "normal" families and individuals, work in the area of personal and family strengths and potentialities has been minimal. There is now increasing recognition that studies of well families and individuals can make a valuable contribution to the therapist.

A number of additional methods and instruments have been developed as a result of the personal and family strength research and are in the process of being evaluated. Of particular interest to the therapist is the Inventory of Personal Resources. This instrument is designed to give the user an overview of the broad range of his personal resources and strengths and is in the process of being field tested. Efforts are underway to secure foundation support for the personal and family strength research.

It is anticipated that when adequate financial support has been secured, an interdisciplinary team approach will be brought to bear on this work. New thinking as well as the exploration of pioneering and experimental approaches is urgently needed to help people grow in health and to use their potentialities. It is hoped that this paper will in some measure serve to stimulate and encourage the therapist to explore possible application of research findings to individual and group therapy.

Shifting patterns of affection: Transitional figures

All those who deal with the developmental aspects of affectional behavior have recognized the necessary turning outward from the family in normal development for mature fulfillment of these needs.

Also recognized has been the transitional nature of this response. It has never been regarded as a simple switching from parental attachments to an adult love relationship.

Ausubel (1) describes and discusses the transitional social sex role which occurs in normal adolescent development, but he confines his discussion to describing expected roles and the social pressures which force both males and females to follow them.

Mead (2) describes the training offered to the young in other cultures by persons outside the primary family group (mother, father, siblings). This training was described as occurring on a formalized basis prescribed by the culture. There was no

attempt to draw parallels to our culture where such interaction occurs in the development of extrafamilial affectional behavior, though on an informal basis. Other writers have indicated the universality in normals of the outward directing of affectional impulses in adolescence, but they have not described the transitional persons who serve as catalytic agents in the shifting of affection from the family to the peer group.

This paper is a summary of observations on a series of individuals, both normals and patients, and their affectional patterns during childhood, adolescence and early adulthood. The article will also deal with perhaps the most important and least understood shifts which take place in development. This is important to both

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parents and their offspring. It occurs when there is a shifting from the primary source of love and affection—parents—to other figures in the environment. Characteristically, in normal development this movement is away from parents as love objects to other environmental figures—both male and female—around them. In some cases this transition may occur as early as childhood. When it occurs in this period, the shift continues for a long period, in which initially peripheral figures are perceived to take on some of the characteristics and roles of the parents, even if for very brief periods of time.¹

For example, the child may spend the night or several days with relatives or close friends who will be permitted to fulfill all the roles normally carried out by the parent. Active play during this period also takes on the character of "trying on" a more advanced personal role for the child.

Sometimes the shift is not gradual and young persons are observed to make what appears to be a sudden and often traumatic (for both the parent and himself) separation from the primary family constellation.

Evaluation of families in which this has occurred reveals that two factors have occurred: First, the young person has implicitly acted out through fantasy, play and, in some cases, constructive planning, a new role for himself which his family could not or would not tolerate. Thus, a gradual separation was not possible. This required that the break be sudden or not at all.

Since the movement from the primary family constellation represents only a phase

in the total emergence of the mature adult personality pattern, it too is subject to distortions and the fixating of behavior at this level. For those who have sought out transitional figures of the same sex, such arrestation may lead to homosexual behavioral manifestations and consequent rejection of the typical male role.

Another, very tentative in his interactions, may fear to go beyond this dependency on a transitional figure and thus he becomes one of a familiar and well-identified type in the American culture—the adult individual who is attached to a married family as a friend, who associates closely with the family unit, serves as a companion when the oppositely sexed family member is out of town, is the person invited as a date or escort at parties and functions when someone needs an extra partner but who lacks sufficient ego strength to establish a marriage or home of his own.

Fortunately, for the majority of persons this aspect of their development does not represent a terminal point. It is an anxiety-reducing introduction into the extrafamilial world. It is also a safe medium for the transferring of strong affectional needs away from the parent. This occurs before these persons feel sufficiently mature, secure and self-assured in being able to convey these feelings to an intended mate.

No attempt will be made here to deal in detail with those abnormal aspects of development in which the child may not make or is not permitted to make a separation from the primary family constellation, nor will it attempt to deal with other semisymbiotic relationships and ties which may prevent a more global affectional pattern on an extrafamilial basis.

It is possible to take a strictly analytic viewpoint and speak of early affectional

¹ Unlike introjection and identification wherein the child, adolescent or young adult takes on the behaviors or values of the peripheral figure, with transitional figures, these values and behaviors are projected onto or perceived in them.

sources as developing from the oedipal relationship or, if preferred, it is possible to speak in more general terms regarding the positive love relationship which a child may have with the parent of the opposite sex. The theoretical orientation does not appear to be crucial to the description of the complex love relationships which are a part of the family group and should not affect the discussion of transitional figures.

It is generally agreed that in the normal development of the child there is an affectional bond built up between the child and one or both parents. As part of growing up, these relationships undergo change. It is necessary for the individual to shift away from the family to other affectional sources in the environment who can more nearly satisfy his needs, which are developing and partially unfilled.

In cases where *all* affectional needs are met, the child probably would not turn away from the home to other figures; rather he would be content to remain in this more primitive state of emotional development.

But what of the figures to whom these children turn in adolescence when they leave the secure (in the cases of normal children) or affectionally distorted (in the case of disturbed individuals) relationships and seek other sources of gratification?

The term chosen to describe this individual is that of transitional figure. This has been done because rarely, if ever, is affection transferred from the primary family constellation to a love object who is accessible for the more dramatic and independent role of love, marriage, and complete independence of the family, except in cases of a traumatic shifting of affectional sources.

More characteristic is the transfer of affection to an intermediary figure. An example is to be found in the transfer of affections away from the mother to the teacher by students who see her not only as a

mother figure but as a love object as well. She is external to the home, in frequent and close proximity, yet she is nearly as inaccessible as the mother.

This is perhaps more dramatically brought out in observing teenagers in their relationships with married persons of the opposite sex with whom they share a great deal on a nonsexual or emotional basis. In general, the individual chosen is sufficiently older than the teenager so that many of the possible complexities and potential for acting out are obviated. There can, however, develop quite complex and traumatic situations if the figure chosen for this transitional stage is not sufficiently mature to handle the attachment which has developed.

In the community there are a number of individuals with whom this transition is made quite easily. Both male and female, they are active in providing a strong source of identification in some cases, or in serving as a love object for the young person. In most instances these men and women who attract young persons to them are warm, outgoing, emotionally healthy individuals who, because of a lack of children of their own, the fact that their children are grown, or based on the need to be of service to others, devote a portion of their time to young persons in the community around them. They tend also to possess some of the characteristics of the parent and other characteristics which make them unique, exciting and interesting. They also appear to be sufficiently mature, in most instances, to be able to maintain the emotional distance that is required by the young person if he is to feel safe and secure.

There are other instances where young persons have turned, because of emotional distortions in their development, to less healthy figures. These are adult individuals who act out needs through their con-

tacts with young persons. In many instances these persons are sought out by young persons seeking support for their hostile and asocial impulses.

These impulses cannot be easily acted out with or in the presence of healthy individuals, either in their own age group or with those who play the role of transitional figures.

The negative transitional figures, having many unresolved problems of their own, consciously or unconsciously attract to themselves the young person who is uncertain in his identification and unsure of the acceptability of his patterns of behavior.

It is characteristic of disturbed young persons that they seek out transitional figures of the same sex. This is done because of the unresolved conflicts they have experienced in the realm of identification and in the establishing of their basic sexual role. This is not a manifestation of recent trauma or difficulties; rather, it is evidence of a process having its inception in the very earliest years of life.

In effect, these persons are functioning on a pre-oedipal level in their feelings and are seeking to establish a basic relationship which was lacking in their home. Unfortunately, their needs for identification, affection and attention from an older person make them much more vulnerable to seduction or exploitation by older individuals.

Many learn that their rewards from older persons come from either acting out or behaving like some of the more poorly adjusted adults they have turned to for this relationship. They are not able to make the more mature contact with transitional figures which other, more healthy young persons have made.

In normals, the movement of affectional needs to transitional figures may not always

provide a smooth and easy course of action. Many young persons, in discussing these attachments, describe feelings of acute (but temporary) depression and hopelessness. However, it is this very hopelessness of their feelings of affection and attachment for the unattainable person—the teacher, the older married woman or man down the street—that permits them to serve this transitional purpose. It is not totally unlike the hopelessness of marrying the parent but it does contain the turning outward of the emotional need and a seeking for avenues of expression for emotional needs with others.

The inherent dangers in these behaviors is small because were the transitional figure to attempt to use this attachment for purposes of seducing the young person or otherwise distorting this relationship, the original defensive need for establishing the relationship would be destroyed and the young person, except in instances where a serious emotional need or deficiency exists, would, and has, fled from the more intimate level of interaction.

SUMMARY

This article attempted to shed light on one aspect of the developing of social behavior which is seen to occur in normal development, the use of a transitional figure on whom to center affectional needs prior to their emergence in an adult pattern. Some distortions of this pattern were described and discussed.

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A tale of Moses: Post-doctoral interlude

The cafeteria had long since closed for the night. Across the hall, the conference room was now dark and gloomy-looking, far different from its friendly appearance a few hours ago when the group was in session.

Now, after an hour's walk along the quiet paths of the nearly-deserted campus, the three psychologists felt somewhat more benign toward the session that only a short while ago had appeared so frustrating and so futile.

After the larger group had broken up for the day, these three, who until this week had been total strangers to one another, had each gone on a solitary walk, each in his own attempt to escape the profound, even violent impact of the group session. But while each one had sought to escape alone, by some strange coincidence they were inexplicably drawn together, so that now only a short time later, these three so alike and yet so different had become united into a small subgroup, as if for mutual defense and protection against the morrow.

During the quiet walk together, each had

carefully refrained from more than a passing reference to the past week of close group discussions—discussions that sometimes took a personal turn, so that even seasoned psychotherapists sometimes disrupted a scientific discourse by turning their analytic skills upon each other, with devastating effect.

Now that the raw rancor in their souls had subsided, these three had returned to the conference hall only to find the small hallway canteen, too, about to close. While the janitor cleaned and swept about them, they carried their paper cups of coffee to an isolated table in the deserted room for a few moments of quiet contemplation and companionship. Soon each would seek out his bare dormitory room, his home for the week-long-post-doctoral conference.

As if the now open, even if darkened archway to the conference room had revived the residue of the afternoon's tensions, the topic of conversation, like a

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neurotic homing pigeon, returned to psychotherapy.

"It's always the same—always the same. Every year I come to these sessions looking for something new and inspiring. Each year we start with how to make people out of our patients, only to have the research boys dissect, bisect, and analyze them. They test, evaluate, and diagnose their troubles. They lay open their dynamics and motives until I can no longer tell whether we are talking about a fellow human being in distress or whether we are taxidermists working on the head of a bull moose to be hung on the trophy room wall." The younger man ground his cigarette in the ashtray with aggressive bitterness.

His two listeners made no comment on this return to the forbidden topic, but continued nursing on their paper cups of coffee in sullen silence.

At last the young woman, her doctoral degree still shiny in its newness, turned to the older man with mild baiting:

"Why don't you come out with one of your cynical, biting comments, Doctor? We have been hearing them all day."

"Cynicism is the defense of sensitive souls before fools . . ." he began.

Then, chagrined at having risen to the bait, he fell silent, staring moodily at her with mingled sarcasm and coldness.

Suddenly, seeing her in her youthful aspirations—so eager to learn, so intellectual, so sophisticated, and yet so childishly naive—and remembering the 25 experience-rich years since he himself first had struggled with the complexities of trying to relate neatly-organized textbook data to the very messy problems of real human beings, striving to find some means, however inadequate, of communicating with the soul of another across the deep no-man's

land of schizophrenia—gazing abstractedly at her youthful face, he muttered as if to himself, "Yes, my dear young doctor. Some day you, too, will learn that the heart of another is indeed a dark forest."

Then, in a more relaxed mood, he continued, "You know, years ago I used to teach. I remember the fresh, eager graduate students in psychotherapy. They had had the regular courses in testing, research methods, statistics, and the rest—and knew so well how to take people apart. Only they seemed to forget that man—even a psychotic—is more than the sum of his parts. All of us professors were so efficient in our work, preparing the student for the examinations . . ." His voice trailed off in meditation.

Speaking as if to himself, he mused, "But I, who wanted my students also to see man again as a *person*, I had no neat synthesizing tool that could be used. I guess I became sufficiently discouraged so that for the past dozen years I have worked in clinic settings, limiting my work to severely disturbed patients, where the person—not the theory—has to come first."

Looking sharply at his two younger colleagues, the man suddenly smiled and continued, "When Ralph here was talking a while ago, complaining about this very natural, almost unavoidable, tendency to fragment man and to view each part of a troubled soul as a separate and discrete entity, I was reminded of a story I was told when I was a child. Since our young Naomi in some respects still seems like a child, I'll tell you two this little tale. And just so that it may be in keeping with the high academic level of the austere group of which we are currently a part, I'll dress it up a bit in our own professional jargon. I call it:

A Tale of Moses

About 30 years had passed since the Jewish tribes had left Egypt, and during all of this time they had been wandering about in the great desert under the leadership of Moses. They made few contacts with the other wandering tribes, and apparently even fewer significant contacts with the petty kingdoms that ringed the desert wastes. In spite of the somewhat paranoid-like seclusion of this wandering group, however, occasional reports of their existence did penetrate to the outer lands.

Thus it happened that one of the neighboring kings received intelligence of these wandering people, with the result that he sent out reconnaissance observers.

In due time these cultural anthropologists returned to their king and gave a glowing report of these Jewish people and of their day-to-day activities. They pointed out, for example, that they were originally a nomadic people who had been extremely self-sufficient and independent until they had settled in Egypt long years ago. They had then, however, become somewhat more urbanized and dependent, deteriorating, in fact, almost to the point of complete slavery.

Then, because of some little-understood social upheaval, these migrants, like so many early-day Oakies, had abandoned their home communities and had set out for some unknown destination where they hoped to better their condition. Apparently they had again lost sight of or abandoned their original objective and had now for a whole generation been a huge, seemingly disorganized and isolated nomadic group, making little contact with other cultures.

The report continued to describe, in rather unflattering terms, the social dis-

organization, the seeming inability of this group to readapt themselves to a nonurban environment. Numerous cases of sporadic revolt against leadership and against authority were reported, and the many apparently senseless changes in objectives were cited.

Although the reports as a whole were descriptive of an ignorant, unorganized, haphazard tribe, there were hints of the presence of a great leader who had brought these people out of Egypt and who had kept them together as a unit through these many difficult years, forcing them to maintain their identity and self-sufficiency in a barren desert, by sheer virtue of his powerful presence.

The king was very much impressed by the reports of this man's administrative abilities, and, remembering the state of his own treasury and the condition of his internal accounting system, wondered whether a man who could maintain and administer a large tribe of wandering nomads in the desert might not prove a valuable adjunct to his own staff. Any man should be overjoyed to receive such an honor, and besides, the king reasoned cannily, 30 years in the desert for a city-bred man might well inspire even a zealot to dream of a return to civilization.

Accordingly, the king dispatched his chief of protocol with two guides to seek out Moses in the wilderness and to invite him to the royal court for an extended visit.

Since the government was not at that time authorized to offer travel allowance and per diem pay for job applicants, arrangements were made to have the tribal leader appointed as a visiting professor and consultant to a special, court-sponsored seminar.

After much searching (since Moses and

his tribe had moved since the earlier reconnaissance checks) the king's emissaries finally did locate the great leader of the Jewish people.

Because of the crowded waiting room, the messengers experienced considerable difficulty in obtaining an audience with Moses, and even after they were conducted into his presence, their prepared speech was repeatedly interrupted while various members of his staff and even drop-in callers brought up endless administrative business. After many false starts, however, the couriers did get across the idea that there was a neighboring king who, having heard about him, was eager to make his personal acquaintance.

Upon hearing of this invitation Moses, shook his head sadly, indicating that in spite of the fact that he had accumulated considerable unused annual leave, he was much too busy to take time off from work just then. Even as he refused the invitation, however, his eyes admired the beautiful, luxurious clothing of the messengers, and a brief reminiscence of golden Egyptian days flashed through his consciousness.

Recognizing his ambivalence, the messengers made it clear to Moses that the king would be willing to make the trip worthwhile for him, and even gave a broad hint of a possible offer as chief administrator at the court, not below a G-S 14 level!

At this point Moses was interrupted by what seemed to be a major administrative emergency, so he excused himself, inviting the emissaries to wait in the coolness of his tent and saying that he would give them his answer as soon as he could return.

For the next few hours the king's messengers had a chance to observe at firsthand the myriad communal activities before the door of their shelter. Many folks came by the tent to ask for Moses, seeking his help with some personal problem. All

spoke kindly to the strange visitors, and in response to their questions, each had some word of respect and veneration for their leader.

When the cool breath of evening swept across the sands, there appeared a lone shepherd, carrying a gourd of water and a small sack of provisions for the visitors' refreshment. He told the king's messengers that Moses had been called to a distant camp because of a disaster to the herd, and that he had been instructed to serve as guide for their return through the mountain pass. He had also been instructed to give them a brief message from Moses to take back to their king: "I am deeply honored, but my duty is here."

There remained nothing for the messengers to do but to return to their king.

Despite his disappointment, the king was very much impressed by the straightforward report he received about Moses. Especially was he impressed by Moses' final message, since it gave recognition to the man's deep human wish to recapture earlier experiences at a royal court, but at the same time it demonstrated that he was impelled by an even deeper sense of duty to remain at his wilderness post.

As the king contemplated this man he became more and more impressed with him, finally deciding that since Moses could not come to the court for an evaluation, he would send his interviewers directly to him and have them submit scientific reports on this apparently rather rare personality.

And so it came about that the king selected an interview-team consisting of a social worker, a clinical psychologist, and a psychiatrist, and gave them instructions to seek out Moses and render a comprehensive report on him.

Again, Moses received his visitors kindly and showed considerable interest in their

research project. He indicated that although he would have little uninterrupted time, he would be willing to do whatever they needed. He also indicated that they could interview such collaterals as they chose, and he publicly instructed his people to co-operate in giving such background and social history or other information as the visitors might request. He even gave them access to the research notes which he himself had been preparing for his brief history of the Jewish people.

Thus, while the social worker gathered data on the Moses family and background, the psychiatrist reviewed the medical and psychiatric history of Moses and conducted extensive interviews, evaluating his hopes and his dreams. The psychologist was able to gather a whole attaché case full of raw test data covering every conceivable area, from dynamics to occupational interests and psychosexual maturity.

At the end of their per diem allotment, the three interviewers were more than eager to escape the hectic survey area and the heat of the desert and to return to their air-conditioned laboratory-clinic where, with the help of their IBM machines, they could leisurely evaluate and analyze their raw data and prepare their research summary.

In due course the reports were prepared (one original and four carbons, all in the form prescribed by the Handbook), and with proper ceremony they were presented to the king.

In those long-ago times, just as now, kings had much difficulty in reading psychologic case reports with their rather esoteric jargon, but this ruler struggled valiantly in an effort to review the bulky combined records. He was quite horrified at the total impression gleaned from these objective analytic evaluations of a man whom he had thought to be great and generous, a great leader of a strenuous people.

Thus, for example, the social worker in reviewing the man's familial and vocational history had found that he was probably illegitimate and that his parentage was unknown. He had been befriended by the Egyptian royalty, but he had later turned against his adopted people. He had been a delinquent, and to escape the charge of murder had fled into a neighboring country. Here, too, he had been befriended by a native family, only to desert his benefactors again and to return to Egypt where he continued his earlier rebellious behavior by inciting the Jews to open revolt. He had a severe speech impediment, and was known to be at times dependent upon his brother, whereas at other times he was extremely hostile. His relationship with his fellow tribesmen was likewise one of ambivalence, for he vacillated between gentle, almost subservient behavior and extremely vindictive, almost brutal revenge.

The psychologist's protocol followed the social report in all important aspects. He found Moses to be a markedly bright individual but a basically immature and impulsive personality. There were many indices of emotional lability, at times bordering on emotional explosiveness. Anxiety level was high, with a probable retreat into somatization reaction. He was compulsive and obviously he had never resolved his Oedipal situation, for he was even now still vainly in search of the father he had never known.

The psychiatrist verified the previous two reports. He did add, however, that there had been several acute psychotic episodes with periods of hallucinatory experiences, including one when Moses had seen flaming images and another when he had heard mysterious voices speaking to him. His speech difficulties were believed to be of hysterical nature and seemed to be related

to periods of stress and to deep feelings of anxiety and inadequacy.

In conclusion, the psychiatrist added, however, that this man was able to mold other persons to his own needs, and reported incidents that could best be described as mass hypnosis on the part of his followers. There was a large sociopathic component to be detected throughout. This, combined with paranoid schizophrenic-like elements in an emotionally labile personality with a history of homicide as a post-adolescent, clearly made the man a dangerous individual.

After the king had read these three interpretative reports he was deeply troubled. He had heard glowing reports about this man Moses from his traveling cultural anthropologists, who had viewed Moses as a leader of men. He remembered his messenger's description of the day spent in Moses' tent, and of his tender ministrations to his people with their catastrophies and their petty problems.

And above all, he recalled Moses' final message to him, in which there was implied a long-standing desire, after so many years of hardship and deprivation in the desert with a primitive, illiterate people, to taste once more in the twilight of his days the gratifying culture of a settled community—but he remembered above all else the rigorous self-denial, for Moses had harkened to a voice higher than personal desire and had sent his regrets with the poignant phrase: "... my duty lies here."

The more the king pondered on these discrepancies, the more disquieted he became. He read and re-read the reports of his psychiatric team and found their reports consistent with each other. He requested other research workers to check the raw test data, only to have them verify the original conclusions. This man was indeed an immature, emotionally unstable,

hysterical, and, at times, clearly psychotic individual who was capable of homicide—a vindictive man, subject to revengeful rage reactions—a man who would not hesitate to sacrifice his own family and friends in his pursuit of intangible goals and abstract ideals.

After a few days of puzzling, during which the king became increasingly mystified, he decided that since this man could not, or would not, come to him, he would go to Moses.

And so it came about that the king, taking only the two guides who had originally extended the invitation to Moses, set out to view for himself this remarkable leader of the Jewish people.

It was many a day before they located the children of Israel, for they had again moved several times since the last visit and the tribe was, in fact, still on the move when they were overtaken. In the attendant confusion the visitors were unable to introduce themselves and, since by this time their dress was much too ragged from their journey to reveal their true status, their real identity went undetected. Even though they came upon the tribe when they were hard at work, about to repitch their tents after a two-day migration, however, these strangers were treated as honored guests. When their presence in the encampment was announced to Moses, he personally welcomed them and had a tent pitched for their shelter, even before those of his own people were erected.

From the open door of his tent the royal visitor could now witness Moses and his people at work, making ready for the night, and he observed with interest the smooth-working co-operation which soon had their temporary village established.

The king watched Moses ministering unto all with patience, tact and wisdom. Even angry disputants who came before him exchanging rough and bitter words, being ex-

hausted and irritated by the strain of the long day's travel, left as friends after a few quiet words from Moses.

The press of administrative duties was never so demanding but that he had time to help a young child who had become separated from his mother in the rush of the last travel hour. Nay, even the limping stray goat received his spontaneous ministrations.

As the sun set, the bustle of the nomads' village subsided. The flocks were grazing quietly in their new pastures. The children were no longer noisy, being asleep on the floor-mats of their family tents, sheltered and safe, while here and there the cry of a new-born—either child or lamb—could be heard.

Moses, having made arrangements for his guests, now invited them to occupy his own tent while he sat under its wide canopy, working over some records by the light of a lone, sputtering, goat-tallow wick.

The king's two guides were now asleep, exhausted by their search; but the king himself still sat watching the Jewish leader record the births and casualties of the two-day move across the burning sands. Every now and then some messenger came from out of the darkness with a request or a problem and Moses helped find the solution, all the while never ceasing his record-keeping.

Now only the stars shown overhead above the dark and sleeping village. Moses took a large volume out from his leather bags and set about writing in his book the history of the Jewish people.

But now the king could contain his questions no longer. He told Moses who he was and why he had come. He told him that he had heard about him, the desert-leader, from many reports, that he had heard of his kindness, his unmatched ability to rule an unruly tribe with gentleness in a hostile

land. He had heard how Moses had given his people a set of laws to govern their lives, and of how he had fed them and provided for them in the raw and empty wasteland.

He also told Moses how his royal psychology research team had been sent to interview him, and how they, after having administered tests and yet more tests, had analyzed his every word, response, act and motive, leaving no secret dynamic untouched in an attempt to comprehend the real personality structure behind his behavior.

The king now continued to relate how their conflicting reports had disturbed and distressed him, and of how he had at long last come with only these two guides to see for himself what manner of man this leader really was.

At this remark Moses stopped from his laborious writing, if only for a moment, to ask the simple question: "And what manner of man do your analytic psychologists say I am?"

"They tell me that you are immature, emotionally unstable, vindictive, and revengeful. That you are capable of sacrificing your family and friends for abstract ideals and socialistic philosophies. That you have periods of violent and ungovernable rage in which you attack people and destroy even sacred objects. That you have killed your own people; that you are merciless in pursuit of a useless hunt for an ideal father; and that you see things that don't exist and hear voices where no one speaks."

The king, now quite carried away by the intensity of his recitation, swept on: "But what they say cannot be true. I myself have seen you minister unto the lowly and the feeble. I have seen you turn away wrath with a kind voice and a disarming word. I have seen you revered by the aged, respected but not feared by the strong, and loved by the children and the beasts of the

tribe. All of these reports can not be correct. Either these reports are false, or my own senses deceive me . . ."

Moses continued to write his slow, laborious script without looking up from his work. He remained silent while his hand slowly came to a complete halt.

Thus he sat in silent contemplation, his hand hanging idle, as if he were reviewing a whole lifetime of memories.

Slowly he turned to the king and sadly replied, "No, your new soothsayers are *not* wrong. They have seen me as I really am. I must admit that I *am* immature. I *am* emotionally unstable. I *am* vindictive, revengeful, and often given to violence. It has even been necessary for me sometimes to sacrifice my own people for the sake of an ideal. It is true that I have listened to commands that others could not hear and that I have seen things that others could

not comprehend. I have been, and done, all of these things—and more."

Moses turned again to his writing, while the king sat in bewildered silence. After a long period Moses turned to his guest and said, with a touch of sadness but with subdued, yet fierce, pride: "These things I have known all of my life. It is this knowledge that has made me what I am today."

Moses returned once again to his writing. The king arose from his seat on the mat to walk under the stars among the dark, sleeping tents.

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With a gesture of weariness the therapist finished his story. Silently, the three psychologists slowly rose and, dropping their empty paper cups into the wastebasket, stepped through the glass doors into the cool starlit night which covered the silent sleeping campus.

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Adjustment and mental health attitudes in foreign students

The influx of foreign students into American universities, particularly since World War II, has created a unique and challenging mental health problem. Psychological adaptation implies harmony between the needs of the individual and the demands of society. The behavior of foreign students will vary as they find the social environment on the American university campus different from that of their homeland.

The major issue in the present study is the extent and nature of the impact of cultural factors on the adjustment of foreign students, and particularly on their attitudes toward concepts of mental health.

Farnsworth (1), along with many others, points out that education, in its broader aspects, and psychotherapy have the common objective of fostering personality adjustment and growth. However, Murray and Kluckhohn (2) indicate the importance of the mediating factors that bridge the

gap between a cultural pattern and utilization of the pattern by individuals.

The treatment of the characteristic problems of foreign students in a university mental health clinic provides a useful empirical ground for these concepts. This paper is a preliminary report based upon a limited sample.

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THE PROBLEMS OF FOREIGN STUDENTS

During a three-year period the number of foreign students who visited the University Mental Health Clinic was double the number of American students in proportion to their enrollment. Because of this high incidence of foreign students in the patient population, the present study was undertaken.

The first attempt was to identify the specific problems which were expressed to the therapists and which, undoubtedly, were influencing the students' adjustment to the academic and social life of the university. Twenty-four foreign students, ex-patients who had visited the clinic during a three-year period and who were continuing their studies at the university, were originally chosen for this investigation. The data in their records indicated that each student presented multiple reasons which prompted him to seek medical or psychiatric care.

Over 80 per cent of these patients mentioned somatic complaints, such as headache, insomnia, fatigue, muscular pains and gastro-intestinal discomfort. The number of foreign student patients diagnosed "psychophysiological reaction" is about twice the average for all student patients seen during the same period of time.

After clinical evaluation it became apparent that these foreign students indicated three major underlying problems: (1) the different character of American culture, (2) the academic pace of the university, and (3) living at a distance from home.

The three major problems can be analyzed into more specific aspects that were typical of one or more foreign students. A common aspect was the foreign student's unpreparedness to accept some prejudice

as a normal expression of fear and ignorance on the part of the American student.

The forms of dating and courtship and the man-woman relationship on the campus brought another new cultural experience to many foreign students, and constituted a significant source of anxiety.

Other culture-ogenic problems were status conflicts resulting from social class differences or male superiority, hostility toward American women, particular dieting customs, and lack of knowledge about the social graces in American society.

Adjustment to the academic standards and level of achievement set for them at the university was another conflict area. Many students who were excellent in their own countries were unable to maintain the same pace or to fulfill the high expectancy placed upon them as a result of the academic standards of their own countries.

In order to function on the American campus, the foreign student has to relinquish, at least partially, some of his values and adapt new ones with a minimum of guilt and anxiety. It happens frequently that his newly required attitudes have not been properly integrated into his personal system of values. The therapist must understand this type of "foreign student syndrome" from the standpoint of the patient's experience in a new environment, and from the conditioning he received from his own culture.

SUBJECTS AND METHOD

Of the 24 patients originally considered for the study, only 19 responded. The data were derived by interviews and questionnaires. All the patients were males with a mean age of 26.7, and the majority were graduate students. This respondent group consisted of 14 Asian students, six of whom were from Iran, three students from Egypt,

one Greek and one Brazilian. No two patients presented identical answers, and all of them gave more than one response to a specific question.

A weakness in studies of this type is that the same response coming from persons of disparate cultures cannot be interpreted the same way. Since the interviews followed the questionnaires, it was possible to eliminate some of this bias. Also, the size of the group is another limiting factor. The mean number of interview hours was about five. The interview hours ranged from one to thirty, and the therapeutic orientation was mostly supportive and situational. There was no relationship found between their attitudes toward mental health and length of treatment.

The follow-up interviews attempted: (1) to examine the foreign students' evaluation of the treatment process, (2) to study their attitudes toward mental health, and (3) to elicit any change in their attitude toward the American culture.

EVALUATION OF TREATMENT

Reasons for Helpfulness

More than half of the foreign students indicated that talking with the therapist was helpful, and they said that discussing their problems reduced their tension and relieved them from disturbing feelings.

Although relating personal problems did not necessarily lead to insight, it alleviated considerably their physical symptoms. Many somatic complaints dissipated as these patients discussed the symptoms with the therapist. Looking upon the therapist as an exceptionally "kind" figure, because this is his expected role, and knowing that he is always there to be consulted when in need was a source of comfort to many patients.

In spite of language barriers and un-

familiarity with the whole area of psychotherapeutic treatment, there was some insight noted in a few patients as the problem became more clear in their minds and they were able to reach certain constructive conclusions. Finally, two patients found direct advice to be helpful to them, and three patients attributed their improvement to the prescribed medication.

Reasons for Lack of Helpfulness

About 40 per cent of the students indicated that therapy was not helpful to them. In general, they resented being seen by a member of the mental health team at the request of the physician whom they contacted originally. The general feeling among these students was that they wanted a direct answer, whereas the therapist's approach was to encourage the patient to solve his own problem.

It is speculated that the relatively autocratic non-Western social environment tends to create individuals dependent upon external controls. Thus, when encountered with stress, they seek external authoritarian support, with a minimum of reliance on their own resources. Ultimately, such cultural determinants were the main reasons given by the students for not being able to receive adequate assistance.

ATTITUDES TOWARD MENTAL HEALTH

The majority of patients looked upon mental health problems generally as socioeconomic phenomena. Modern concepts of psychological behavior were nearly unknown to these foreign students.

Their responses on attitudes toward mental health were classified in four major groups:

(1) Mental health problems as products

of socioeconomic development. The students in this group considered mental health efforts as an irrelevant luxury which occurs in countries where wealth and leisure are predominant. Others considered economic and educational improvements as the panacea for mental ill health.

(2) Mental health problems as phenomena caused by prevailing value-orientations. These students reacted to certain American customs and mores, and they placed greater value in their own beliefs. They felt that concern toward the mentally ill depends upon the values of society.

(3) Mental health problems viewed from ethical and philosophical standpoints. Lack of religiosity, the absence of morality, and an unsound philosophy of life were related to problems of mental ill health.

(4) Mental health problems as personal psychological disturbances. The two students in this group viewed mental illness as of intrapersonal concern, and as a social adjustment problem.

The majority of patients were concerned with how well their therapists understood the total cultural area. Comments were made on the cultural or value systems of their countries, implying that the understanding of the conventional requirements of their culture was indispensable for the therapist if he were to guide his patients successfully toward an adequate adjustment to American culture.

Suggestions for improved treatment were focused on the areas of direct guidance, the language barrier and cultural inquiry. Some patients felt that direct advice on a few specific problems, such as sexual, racial, and social, would have been more helpful to them. The majority of the patients who commented on the cultural aspects of treatment hoped that the therapist would have a high degree of knowledge about foreign countries, particularly of those political and

economic conditions which had a significant impact upon their sojourn in America.

Talking over "nervous problems" and physical symptoms with nonmedical personnel was a new experience to many of these patients. Some, in the beginning of treatment, refused to talk about their needs and feelings, and they demanded medication by indicating that this was the way all physical symptoms are treated in their own countries. Others had difficulty seeing the relationship between mental states and physical complaints; or they were more reluctant to admit an underlying emotional problem.

ATTITUDE CHANGE TOWARDS AMERICAN CULTURE

The assumption that personal interaction in the form of patient-therapist relationship would lead to changes in attitude toward their host country was not borne out in the study. The opinions expressed by the respondents rather clearly indicate that personal associations, whether they take the forms of professor-student, employer-employee, host-guest, or therapist-patient relationships are but one part of the total new experience.

The present study, in its limited scope, indicates that even a minimum of experiences will contribute to the foreign student's selective perceptions and attitudes, whether they are favorable or not. Those who encountered unpleasant experiences seemed to look deliberately for things to criticize in the American social system.

Furthermore, it was repeatedly brought out by the patients that they had developed their images of America before they came to the United States. Also, they manifested some ambivalence in their expression of opinions about the United States as they viewed her as a teacher, leader and supervisor.

It is likely that other American universities which host foreign students will indicate similar experiences. A parallel study conducted with American students in other countries would be interesting.

SUMMARY

A follow-up study of foreign students who visited a university mental health clinic on an outpatient basis indicated that:

(1) More foreign students required psychiatric assistance than American students;

(2) The majority benefited from therapy, although their complaints were predominantly of a somatic nature, and they showed preference for medication over psychotherapy;

(3) Most of them associated mental illness with socioeconomic conditions; and

(4) Their attitude toward American culture did not change as a function of treatment.

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Bilingualism: A brief review

Bilingualism has been variously defined by different authors. For example, Arsenian (2) defined it simply as the "use of two languages by the same person," while Pinter and Arsenian (6) limited the use of the term to "a person who was born and brought up in a family where two languages are used interchangeably."

Anastasi and Cordova (1), on the other hand, proposed to discriminate two types of bilingualism and to deal with them accordingly. The first is called "linguistic bifurcation" and here we find the restriction in the learning of each language to certain situations such as home, school and the like. The second is called "bilingual parallelism" and, in this case, we do not find any situational restriction.

In this paper, the term "bilingualism" is used in terms of "linguistic bifurcation," as defined above by Anastasi and Cordova. More specifically, bilingualism is a problem which confronts those children who are taught in one language in their school, while their family members depend upon another language as the means of their communication in home.

This linguistic conflict, or the double role-taking, has posed many problems in school situations. Since the current methods of instruction in school heavily depend upon verbal comprehension and other verbal skills, those poor in the knowledge and use of the particular language involved are expected to be severely handicapped in their learning. Since the groups most conspicuously handicapped in this regard are those of foreign ethnic origin, many studies have been concerned with this phenomenon of bilingualism among immigrants.

Almost all reported studies are devoted to exploration of the relationship between bilingualism and verbal intelligence, and of the effects of bilingualism on school adjustment. The bilinguals typically show poorer performance on the verbal types of intelligence tests, and many researchers have tried to find whether this is due to some handicaps in linguistic skills. Others have suspected the possibility that bilin-

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gualism causes a high incidence of emotional maladjustment or mental disease, since the handicap in linguistic skills necessarily impairs good interpersonal relations and results in tension and anxiety among the bilinguals.

A close association of the three phenomena of ethnicity, bilingualism, and retardation is well-known, and it seems difficult to determine which one is the cause and which is the effect. Bilingualism, then, is not a simple topic to study, but its practical implications for educators and pupils are many. What do we know about bilingualism? This is the topic of this modest review of papers.

BILINGUALISM AND VERBAL INTELLIGENCE

A rather standard procedure used in many researches on bilingualism is the comparison between the performance of bilinguals on verbal tests and on nonverbal tasks. The rationale is that bilinguals would show poorer performance on verbal tasks than on nonverbal tasks because of their handicaps in linguistic skills.

If tests of intelligence are administered to bilingual and monoglot children and the results compared, bilinguals are expected to show poorer performance on verbal tests, but they would show comparable results on nonverbal tests. If they show poorer performance on nonverbal tasks too, over-all mental retardation should be suspected. Many studies are cross-sectional rather than longitudinal and the results are not necessarily consistent with each other.

English—Yiddish

Pintner and Arsenian (6) conducted a study concerned with the relationships of

bilingualism to verbal intelligence and school adjustment of 469 Jewish children, all native-born and coming from the same metropolitan neighborhood. These subjects were in the sixth and seventh grades of a public school in Brooklyn, N. Y., and they had been confronted with the problem of bilingualism from their infancy, because elder members of their families preferred the use of Yiddish to the use of English. The age range of the subjects was 121–180 months, while 90 per cent of them were between 131 and 160 months old.

The researchers used the Hoffman Bilingual Schedule to determine the extent of bilingual background of the child and the Pintner Intelligence Test (Form A) for the measurement of intelligence.

They computed a correlation coefficient between the results on these two scales and found it to be only .059. They then took the top and bottom 20 per cent of the population measured by the Hoffman Schedule and compared these two groups on their ratings on the Pintner Test. Differences in I.Q. means were not statistically significant. In addition, these same two groups were compared on their I.Q. ratings on the Pintner Non-Language Test, but the difference again was not significant.

The authors concluded that the association between bilingualism and intelligence is practically zero, and the differences in I.Q. on both verbal and nonverbal intelligence tests of high and low bilingual groups are statistically nonsignificant. According to them, these results indicate that Jewish bilingual children of the sixth and seventh grades born in the United States have acquired the English language sufficiently well so as not to be handicapped in their performance on a group verbal intelligence test of the usual type. They pointed out

that the situation might be different among bilingual children other than Jews.

To see the relationship of bilingualism to school adjustment, the authors further administered to the same subjects the Pupil Portraits Test, Form A. This test consists of 100 items divided into five parts and purports to measure pupils' adjustment to the general school environment, to the teacher, to the classmates, to the family members and to himself.

When the two pupil groups (top 20 per cent and bottom 20 per cent on the Hoffman) were compared on the Pupil Portraits, no statistically significant result was obtained. Therefore, the authors concluded, bilingualism in this particular population bears no relation to verbal intelligence and school adjustment as measured on the specific tests employed.

As the authors correctly pointed out, their results should be interpreted strictly in terms of this specific population. Language, unless dead, cannot be adequately studied without considering the people which use it and the environment in which they exist. Affective elements are inseparably merged with any language and their influence most probably bears relation to bilingualism and its concomitant behaviors.

English—Gaelic

Stark (10) conducted a study on the effect of bilingualism on general intelligence in certain Dublin (Eire) primary schools. He chose 271 bilinguals (10-12 years old) from 5 all-Irish schools (instruction in Irish; English used in homes) in Dublin as his experimental group and 297 monoglots (10-12 years old) from 5 non-Irish schools (instruction in English) in Dublin as his control group.

He used the Dawson Mental Test, Form B (English version for the monoglots, Irish

translation for the bilinguals), the Dawson Mental Test, Form A (both groups in English), and the Passalong Test. The Dawson Test is a group verbal test and the Passalong is an individual performance test.

First, 271 bilinguals and 297 monoglots took the Dawson, Form B. The monoglots took the original English version, and the bilinguals took the specially prepared Irish translation which correlated .84 with the original version. They found a significant difference of five points in favor of the monoglot group at the age of 11-12, with the difference at the earlier age (10-11) so small as to be negligible. Next, 65 of the bilinguals and 104 of the monoglots, both selected randomly out of the original groups, were administered the Dawson, Form A, in English. Surprisingly enough, significant differences of 13 points (age 10-11) and 7 points (age 11-12) were found in favor of the bilinguals. Finally, 41 of the bilinguals and 41 of the monoglots, again randomly selected, were administered the Passalong Test and here, the author could not find any significant difference between the two groups.

The author concluded that the early acquisition of a second language at school does not necessarily weaken the home language (English in this case); indeed, it may strengthen it. Children with an innate verbal facility of a high degree may find the early acquisition of a second language beneficial to their mental development.

Although his use of a control group is commendable, Stark's treatment of the experimental and control groups is not without flaws. Apparently he took simple random samples out of his original groups of 10-12 years old when he administered the Dawson, Form A, and the Passalong, and then analyzed the results according to

the age of subjects involved; i.e., 10-11 and 11-12.

This procedure makes it difficult to compare the results of the Dawson, Form A, with those of the Dawson, Form B, and we are not sure whether the observed reversal of the test results is really representative of the original groups of 271 and 297, respectively. In addition, the Irish translation of the Dawson Test compels us to compare the performance of the bilinguals on this version to the norm group on which the original English version was standardized. It is doubtful whether the five-point difference is really significant under such a condition.

Morrison (4) conducted a study in the island of Lewis, Ross-shire, on the possible handicap of the bilinguals (English-Gaelic) on English verbal intelligence tests. His subjects were 77 pupils of 11-year olds from 5 rural elementary schools in the island (whose families used only Gaelic in their homes). He chose the Moray House Test 21 and the Burt's 1925 Northumberland Intelligence Test (both verbal), and the Spearman's Visual Perception Test, Part Three, and the Stephenson's G-Test, Number One (both nonverbal) as the instruments.

According to Morrison, the results, while not conclusive in the absence (at that time) of norms for the Stephenson Test and of adequate norms for the Spearman Test, afforded some evidence for the thesis that these children are, in fact, handicapped.

The mean score on the Spearman Test (nonverbal) appeared to be significantly higher than a value to be expected from the mean scores on the two verbal tests, while the positive skewness of the "verbal" score-scatter and the negative skewness of the "nonverbal" score scatter seemed to yield some support to (Decroly's) hypothesis that more intelligent children may be

less handicapped by their bilingualism than the less intelligent.

Unfortunately, Morrison did not use any control group and, in addition, his choice of unfamiliar test instruments tends to discourage us from discussing his conclusion further.

English-Italian

Darcy (3) studied 212 children of pre-school age ($2\frac{1}{2}$ - $4\frac{1}{2}$) in 10 nursery schools in Brooklyn, N. Y. The experimental group of 106 bilinguals (Italian in home, English outside) and the control group of 106 monoglots (English in and out of home) were divided into 4 age levels of 6 months each and, at each age level, matched in number, sex and father's socioeconomic status. She chose the 1937 Stanford-Binet, Form L (verbal) and the Atkins Object-Fitting Test (nonverbal) as her instruments, and administered these with an interval of less than 36 hours, while balancing out the order of test administration.

On the Stanford-Binet, the monoglot (control) group showed a significantly higher performance than that of the bilingual (experimental) group. Sex difference was nonsignificant in both groups. On the other hand, the experimental group showed a significantly higher performance on the Atkins than did the control group. Here again the sex difference was nonsignificant. The observed tendency for the monoglots to be superior to the bilinguals on the Stanford-Binet but inferior on the Atkins was consistently observed in each age and sex group both in terms of I.Q. and M.A.

When the correlation between the Stanford-Binet and the Atkins was computed, it was found to be .61 for the bilinguals and .62 for the monoglots. These values are too low to warrant the substitution of one

have a strong ingroup feeling, a low occupational level, a low education level, and a relatively high proportion of cases with subnormal intelligence. The dark-skinned Puerto Rican migrant is encouraged to remain Spanish-speaking, since, as a foreign-speaking Negro, he tends to enjoy higher status in the United States than does the native American Negro. Therefore, Puerto Rican children remain virtually monolingual until enrolling in school. Various forms of linguistic and personal maladjustment result from the cultural conflict confronting these second-generation immigrants.

BILINGUALISM AND LATER EMOTIONAL DEVELOPMENT

Spoerl (9) studied various aspects of emotional adjustment at college level as functions of the experience of having been brought up through childhood in a bilingual environment. Her subjects were 101 bilingual (experimental) and 101 monolingual (control) students enrolled at the American International College during the fall semesters of 1939, 1940 and 1941.

The 101 bilinguals consisted of 35 women and 66 men and the group represented 16 different foreign languages (none from Asia). Of her subjects, 69 bilinguals and 69 monolinguals were of the Survey group, while the rest of them, 32 bilinguals and 32 monoglots, were of the Intensive Study group. In the former, the two groups were matched on the result of Henmon-Nelson Test, age and sex, but not for socioeconomic status. On the other hand, the subgroups of the Intensive Study group were matched on all of these factors.

Spoerl first studied the emotional adjustment in the Survey group and felt that three principal lines of evidence in this

group point in the direction of a possible emotional maladjustment as the most important differentiating factor between the bilingual and control groups.

These three were: (1) Mortality during the first year in college; the rate was 16 per cent in the bilinguals and 12 per cent in the monoglots (the difference not significant), but 27 per cent of the dropouts from the bilingual group reported "personal maladjustment" as the primary reason of withdrawal, while none of the monoglot dropouts reported it as a reason. (2) Number of interviews sought besides the routine interviews with student personnel workers; 37 per cent of the bilinguals sought further interviews while 22 per cent of the monoglots did the same (the difference not significant). (3) Answers on the Bell Adjustment Inventory; the difference was significant. The bilinguals showed higher maladjustment and a *chi-square* analysis made it clear that items concerned with feelings of disappointment on the part of parents, domination by parents, parental criticism and envy of the happiness of others revealed significant differences between the bilinguals and the monoglots.

Deeplying home maladjustment and feelings of social inferiority were suspected among the bilingual students. The latter, however, stemmed from the lower socioeconomic status of their families and not necessarily from bilingualism. Therefore, the maladjustment caused by bilingualism is essentially in the area of intra-family and home relationships.

Spoerl then turned to the Intensive Study group and administered the following four tests: (1) The Allport-Vernon Study of Values; only one section dealing with social values clearly differentiated the two groups, and the bilinguals showed a greater variability in this score possibly because of

either aggressive or retreating reaction to social frustration. (2) The Bogardus Test of Social Distance; although the difference was not significant, 80 per cent of the bilinguals revealed greater social distance than that shown by the monoglots. Those of seven language groups (Greek, Italian, Lithuanian, Polish, Portuguese, Russian, Syrian) constituted these 80 per cent, while the remaining nine language groups (Armenian, French, Finnish, German, Swedish, Ukrainian, Yiddish, etc.) did not show any significant difference. (3) The modified Kent-Rosanoff Association Test; among 21 especially added words, 11 (such as Yankee, Foreign, Society, Different, Language, Respectable, Alien and Citizen) showed difference. This was interpreted as showing a lack of environmental identification, which seems to be extremely important in the emotional insecurity of the bilingual students. (4) The Morgan-Murray Thematic Apperception Test; the results showed the more intense family conflicts were among the bilinguals rather than among the monoglots.

Spoerl concluded that although some of the maladjustment may stem from social pressure, the major conflict is within the home. The final question that must be considered is whether this home conflict is a direct result of bilingualism or whether it is based rather on the cultural conflicts of the "second generation;" i.e., the native-born children of foreign-born parents.

The (Stonequist's) concept of the *marginal man*, defined as one who exists on the margin of two cultures but is identified with neither, seems relevant here. The emotional maladjustment of the bilingual students seems to be due more to this cultural conflict than to the fact that they were brought up in a two-language environment. Language is important as it

becomes the *symbol* of the culture, and tension is greatly reduced when the parents give up their old culture and with it, the symbol (language).

Although Spoerl's data are not conclusive, her concept of cultural conflicts as the major source of difficulty would seem to be the most plausible hypothesis. Language is the medium of culture and, in addition to being a code, it is also a tradition. One cannot discuss language without paying attention to the culture it represents. When dealing with bilingualism, we are dealing not only with the acquisition of two languages but also with the cultural conflict or fusion between two nations.

CONCLUSION

Arsenian (2) presented an excellent review of this problem of bilingualism. He pointed out that the problem is a complex one and that not all bilinguals use their two languages with an equal degree of efficiency. He then proposed seven techniques to be employed in investigating various aspects of the phenomenon: (1) background questionnaires, (2) association techniques and knowledge tests, (3) rating scales, (4) similarity measure between the two languages involved, (5) age measure to know when the learning of the second language occurred, (6) method of learning, and (7) attitude toward the second language.

He summarized the findings on the relation between bilingualism and mental development as: (1) bilingual children as compared with monoglot children of the same age and environment are neither retarded nor accelerated in their mental development, this being especially evident when these two groups are compared on non-language tests of intelligence; and (2) when verbal tests of intelligence are used,

monoglots show, in general, a superior performance to the bilinguals. The older the child and the higher his level of educational attainment, the smaller the discrepancy between these two groups. Apparent retardation of bilinguals varies from place to place and from group to group.

The bilinguals might therefore show language deficiency, but the extent and the period of such deficiency seem to depend upon certain factors, such as the extent of educational opportunities, intelligence, method of instruction and so forth. Such language deficiency reflects itself in the child's school performance, especially at the elementary school level. This handicap becomes stabilized by the first year of college.

In most bilingual situations, the two languages involved do not carry equal social prestige and this represents the complex psychological and sociological phenomenon of culture conflict. A truly bilingual situation where the two languages are on equal footing is rarely encountered.

As for the learning of the second language, Arsenian (2) states that the earlier the acquisition of a second language, the stronger its impression upon the individual and the more effective its use. A simultaneous learning of two languages from infancy has no detrimental effect on a child's mental development, provided the following conditions are met: (1) when a consistent method of source and presentation of the two languages is observed; i.e., "une personne, une langue;" (2) when psychological barriers or negative affective conditions, such as inferiority or superiority of the languages involved, or national and religious animosities sometimes associated with language is absent; and (3) when the languages are learned by spontaneous, informal or play methods, and not by formal and task methods.

It is clear that although for the privileged minority bilingualism needs not be a handicap, in the majority of cases it does result in retardation in school and inferior performance on the verbal tests which are the primary medium of child assessment in school. Intellectual development is an important part of the general learning of one's culture, and since language is the primary means of such cultural learning, it follows that an impairment in language is expected to affect all areas of human intellect. Research on bilingualism and its related problems is not complete yet, and more studies of longitudinal and human-ecological nature are strongly urged both from manpower approaches and from mental health considerations.

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Mental disease among native and foreign-born whites in New York State, 1949-1951

INTRODUCTION

In 1910, native-born whites constituted 69.6 per cent of the total white population of New York State.¹ Since that date the native white percentage has grown steadily, until it reached 82.0 per cent of the total in 1950.² Primarily because of the restriction of immigration, the foreign-born whites have decreased from 30.4 per cent of the total in 1910 to 18.0 per cent in 1950.

Throughout this period there have been

similar trends in the nativity of first admissions to the New York civil state hospitals. The native-born constituted 52.4 per cent of the total first admissions in 1915 but 71.2 per cent in 1950, whereas the corresponding percentages of the foreign-born decreased from 47.5 to 28.7. In each year, however, the percentage of the foreign-born among first admissions exceeded the corresponding percentage of foreign-born in the general population, whereas the native population represented a smaller percentage of the first admissions than their expected quota.

Such statistics can be duplicated for the United States as a whole and have led to diverse opinions as to the relation of immigration to the incidence of mental disease. Prior to the second decade of this century, the arguments for the control and limitation of immigration were based largely upon economic grounds. Subsequently, the arguments turned to the relative biologic fitness of various groups of prospective immigrants.

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This is the seventh of a series of eight studies describing the frequency of mental disease among ethnic and national groups in the United States.

¹ *United States Census of Population, 1950. General Characteristics.* (Washington, D. C.: Government Printing Office, 1952), P-B32, p. 56.

² *Ibid.*

TABLE I

White first admissions to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and mental disorders

Mental disorders	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
General paresis	388	1.1	1.1	233	1.4	3.1
Alcoholic	1,976	5.6	5.8	741	4.6	9.9
With cerebral arteriosclerosis	5,268	14.9	15.5	4,666	29.1	62.3
Senile	3,672	10.4	10.8	3,468	21.6	46.3
Involucional	2,680	7.6	7.9	2,198	13.7	29.3
Manic-depressive	1,762	5.0	5.2	521	3.3	7.0
Dementia praecox	11,671	33.0	34.3	2,131	13.3	28.4
Other	7,900	22.4	23.2	2,062	12.9	27.5
Total	35,317	100.0	103.9	16,020	100.0	213.8

The relative rates of admissions to mental hospitals played an important part in such discussions. Summaries of the literature have been given by Ødegaard,³ Malzberg⁴ and Thomas.⁵

The usual statistics of first admissions to mental hospitals do not provide an adequate basis for an impartial analysis. Statistics for the United States as a whole are slanted, because of the heavy concentration of large immigrant populations in the eastern and north central states. The native-born predominate in those areas of the country where hospital facilities are not as available as in other sections. Hence, it is necessary to limit comparisons to individual states, where such a selective bias does not exist.

This investigation was therefore limited to New York State, and comparisons are based upon white first admissions to all mental hospitals, public and private, during the period from October 1, 1948, to September 30, 1951. This period was selected because the midpoint, April 1, 1950, was the date of the federal census, permitting the computation of average annual rates.

There were 35,317 native white first ad-

missions during this period. Of this total, 11,671, or 33 per cent, were diagnosed as dementia praecox. The second largest category, psychoses with cerebral arteriosclerosis, included only 5,268 cases, or 14.9 per cent of the total. The senile psychoses included 3,672 cases, or 10.4 per cent. Together, these two disorders, both associated with advanced age, included a fourth of the total first admissions. The involutional psychoses followed with a total of 2,680, or 7.6 per cent.

There were 16,020 foreign-born white first admissions during this period. The distribution of mental disorders differed widely from that for native whites. Psychoses with cerebral arteriosclerosis included 4,666 first admissions, or 29.1 per

³ Ødegaard, Ørnulf, "Emigration and Insanity," *Acta Psychiatrica et Neurologica*, Supplement 4, 1932.

⁴ Malzberg, Benjamin, *Social and Biological Aspects of Mental Disease* (Utica, N. Y.: State Hospitals Press, 1940).

⁵ Thomas, Dorothy S., in introduction to *Migration and Mental Disease* by Benjamin Malzberg and Everett S. Lee (New York: Social Science Research Council, 1956).

cent of the total. Senile psychoses followed with 3,468 first admissions, or 21.6 per cent. Together these two groups included half of the total white foreign-born first admissions, compared with a fourth among the native-born. On the other hand, dementia praecox included only 13.3 per cent of the total white foreign-born first admissions, compared with 33 per cent for native-born.

The relative distributions of the mental disorders were influenced by the age structures of the populations. Dementia praecox is a disorder of the relatively young. Psychoses with cerebral arteriosclerosis and senile psychoses are associated with advanced age. Consequently, native whites, with a median age of 29.0 years, were more likely to include a high proportion of first admissions with dementia praecox.

Foreign-born whites, on the other hand, had a median age of 54.2 years, almost twice that of the native whites. Consequently, the foreign-born were weighted with those psychoses characteristic of older ages. More specifically, those aged 15 to 34 comprised a third of the native white population, compared to only 10 per cent of the foreign-born whites. However, those aged 65 and over included 22 per cent of the foreign-born whites, but only 6 per cent of native whites.

Differences in the proportionate distribution of mental disorders are not necessarily a measure of differences in relative incidence. Thus, primarily because of age differences, the proportions of the several groups of disorders differ significantly between native and foreign-born whites. But it is possible for rates of first admissions to vary in opposite direction from proportionate indices. Table 1 shows this to be true in connection with alcoholic psychoses and manic-depressive psychoses. Comparisons of relative incidence must be made, therefore, on the basis of rates of first admissions per 100,000 population. Thus, the rates for

dementia praecox were 34.3 and 28.4 for native and foreign-born whites, respectively. On the other hand, the latter had a rate of 62.3 for psychoses with cerebral arteriosclerosis, compared with 15.5 for natives. Foreign-born whites had a rate of 46.3 for senile psychoses, compared with 10.8 for natives. The average annual rates for total first admissions were 213.8 and 103.9 for foreign and native-born, respectively.

In general, rates of first admissions increase with advancing age. This is especially noticeable after age 40. Among native-born, the rates increased, with one minor exception, to a maximum of 705.7 at ages 75 and over. There were marked sex differences, however. Thus, females had higher rates than males between ages 30 and 49. But males had significantly higher rates at ages 50 and over.

The rates fluctuated irregularly among foreign-born at younger ages, but rose steadily after age 40 to a maximum of 920.9 at age 75 and over. The sex differences varied significantly from those for natives. Among the latter, the rates for males were in excess, except for the involutional period. Among foreign-born, however, females had higher rates at almost all ages. This is generally attributed to greater difficulties among foreign-born females in adjusting to the processes of emigration.

It was shown previously that crude rates were 213.8 and 103.9 for foreign-born and native-born, respectively, the former being in excess in the ratio of 2.06 to 1. This is due in large part, however, to the more advanced age of the foreign-born. Age-specific rates vary about a lower level. In fact, rates were practically equivalent for the two populations between ages 35 and 64. But again there are marked sex differences. Excluding probably fortuitous variations at younger ages, foreign-born males had lower rates of first admissions than native-born

TABLE 2

White first admissions to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	508	1.4	5.4	8	0.1	7.1
15-19	1,872	5.3	76.0	96	0.6	135.4
20-24	3,305	9.4	117.0	235	1.5	158.2
25-29	3,618	10.2	119.6	381	2.4	150.7
30-34	3,331	9.4	110.6	307	1.9	126.8
35-39	3,199	9.1	114.4	502	3.1	116.7
40-44	2,889	8.2	118.3	804	5.0	115.2
45-49	2,435	6.9	124.4	1,139	7.1	124.4
50-54	2,241	6.3	129.8	1,428	8.9	138.1
55-59	1,956	5.5	145.2	1,472	9.2	147.2
60-64	1,763	5.0	167.7	1,654	10.3	178.9
65-69	1,695	4.8	206.1	1,860	11.6	249.0
70-74	1,895	5.4	336.9	1,951	12.2	419.6
75 and over	4,594	13.0	705.7	4,166	26.0	920.9
Unascertained	16	....*	.....	17	0.1	.....
Total	35,317	100.0	103.9	16,020	100.0	213.8

* Less than 0.05

between ages 40 and 59, and the rates did not differ significantly at other ages. Among females, however, foreign-born had higher age-specific rates, but the excess was much less than indicated by crude rates.

It is evident, therefore, that direct com-

parisons of crude rates are inconclusive, because of the age factor. The rates were therefore adjusted to a common base by standardizing with respect to age and sex.

Among native-born whites the standardized rate rose from 142.5 in 1940 to 152.0 in

TABLE 3

*Average annual standardized * rates of first admissions to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	153.1±1.39	157.1±1.35	1.03	166.6±2.29	168.2±2.50	1.01	1.09	1.07
Females	128.7±1.24	141.8±1.22	1.10	155.1±2.26	180.5±2.57	1.16	1.21	1.27
Total	142.5±0.93	152.0±0.91	1.07	163.3±1.62	178.7±1.82	1.09	1.14	1.18

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

1950. During this period, the rate rose by 3 per cent among males, and by 10 per cent among females. Males had higher rates than females, but the excess dropped from 19 per cent in 1940 to 11 per cent in 1950.

Foreign-born whites had a standardized rate of 178.7 per 100,000 in 1950, compared with 163.3 in 1940, an increase of 9 per cent. The rate increased slightly among males during this period, but it increased by 16 per cent among foreign-born females. We may also note that the rate for males exceeded that for females by 7.4 per cent in 1940, whereas the rate for females was in excess by 7.3 per cent in 1950.

The rate for foreign-born exceeded that for native-born by 18 per cent in 1950. The rate for foreign-born males was in excess by 7 per cent. Foreign-born females showed a corresponding excess of 27 per cent.

On the basis of crude rates, foreign-born had been in excess by 106 per cent. By adjusting for differences in the age and sex proportions of the two populations, the disparity in rates was reduced in a significant manner. But the incidence of mental disease varies in accordance with other demographic factors, chief of which is the urban-rural ratio. It has been shown that rates vary with degree of urbanization, and that they increase with great regularity from a minimum among the rural population to a

maximum in the larger cities.⁶ In 1950, 82.9 per cent of the native white population of New York State were living in urban areas, compared with 93.4 per cent of foreign-born whites.⁷

A correction for this differential was made in a previous study, based upon first admissions to all hospitals for mental disease in New York State during 1939-1941. The foreign-born white population had a crude rate of 175.1 per 100,000 population during that period, compared with 91.8 for the native white population. "When corrected with respect to differential sex and age proportions, the corresponding rates became 150.5 and 132.1, respectively. Introducing the additional correction for the urban-rural ratios, the rates became 140.5 for the foreign white population, and 137.7 for the native population. Beginning with an excess of 90.7 per cent, when no account was taken of sex and age proportions, the disparity was reduced to 13.9 per cent, when such corrections were made. Finally, by adjusting, in addition, for the urban-rural distributions, the excess of the rate for foreign-born whites over that for native whites was reduced to only 2 per cent."⁸

A similar comparison cannot be made for 1949-1951, because the definition of urban-rural employed in the census of 1950 differed from that for 1940. The latter was the basis for the classification of first admissions in New York State, according to environment, during 1949-1951, and hence the two are not comparable. A further attempt was therefore made at a comparison according to degree of urbanization by limiting the analysis to New York City. Since 71.6 per cent of the foreign-born whites were in New York City in 1950, compared with 47 per cent of native whites,⁹ the limitation to New York City narrows the environmental differential, although it does not remove it completely.

⁶ Malzberg, Benjamin, "The Distribution of Mental Diseases in New York State, 1949-1951," *Psychiatric Quarterly Supplement*, 29 (Part 2, 1955).

⁷ *United States Census of Population, 1950 Nativity and Parentage* (Washington, D. C.: Government Printing Office, 1954), Special Reports P-E No. 3A, p. 35.

⁸ Malzberg, Benjamin, "Mental Disease among Native and Foreign-born White Populations of New York State, 1939-1941," *Mental Hygiene*, 39 (October, 1955), 555-56.

⁹ See footnote 7.

Foreign-born whites from New York City had a standardized rate of 183.3 per 100,000, compared with 168.8 for native whites, a ratio of only 1.09 to 1. Among males, the difference amounted to only 4 per cent, which is not statistically significant. The rate for foreign-born females was in excess by 13 per cent.

Thus, on the basis of crude rates, foreign-born whites had a rate in excess of that for native whites by 106 per cent. Corrected for age, this was reduced to an excess of only 18 per cent. With a further adjustment for size and density of population, the excess amounted to only 9 per cent. Among males, there was a similar reduction from 94 to 7 to 4 per cent. Among females, the excess was reduced successively from 118 to 27 to 13 per cent.

The preceding comparisons have given average results for the entire foreign-born white population. But the latter consist of representations of many nationalities. Some have rates above the average; others have low rates. In arriving at these rates, certain assumptions were made with respect to age composition. Such statistics are not available for New York State, but are given for the Middle Atlantic Division, which includes New York, New Jersey and Pennsylvania. It was assumed that each foreign-born group in New York State had the same age and sex distribution as the corresponding population in the entire division. This must be a reasonable assumption, in view of the fact that New York State includes a high proportion of the population of the entire division. In the same manner, and for the same reason, the age and sex distribution of the foreign-born in New York City were assumed to be the same as that for the corresponding groups in the urban part of the Middle Atlantic Division.

Two nativity groups stand out with standardized rates well above the average. The

highest rate, 244.0 per 100,000 occurred among Irish-born living in New York City. Swedish-born had a rate of 225.2. In contrast to the latter, Norwegian-born had a rate of only 153.0. The lowest rate, 138.3, occurred among Italian-born. Those born in England and Wales also had a low rate, 141.0. We may note that rates for Italian-born and English-born were less than the rate for all native-born. Russian-born had a rate of 162.9. This is also below the average.

Since the vast majority of Russian-born are Jews, this implies that Jews have a low rate of first admissions. This has been verified in a more definitive investigation.¹⁰ Polish-born had the high rate of 199.6. This population consists of Jews and Slavs in an unknown proportion. But since Jews have a low rate, it implies that Polish-born Slavs must have a rate above the average.

General Paresis

There were 388 native white first admissions with general paresis during 1949-1951, giving an average annual rate of 1.1 per 100,000 population. The maximum rates occurred at ages 45 to 59. This interval included 182 of the 388 first admissions, or 46.9 per cent.

Males had an average annual rate of 1.5, with a maximum of 5.2 per 100,000 at ages 50 to 59. Females had an average annual rate of 0.8. The maximum rate for females, 2.7, occurred at ages 55 to 59. In general, males had higher rates than females at corresponding ages, but the relative excess was higher after age 45.

Foreign-born white first admissions with general paresis totaled 233 during 1949-1951, or an average annual rate of 3.1 per

¹⁰ Malzberg, Benjamin, *Mental Disease among Jews in New York State* (New York: Intercontinental Medical Book Corporation, 1960).

TABLE 4

White first admissions with general paresis to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	2	0.5	*	..	...	...
15-19	7	1.8	0.3	1	0.4	1.4
20-24	2	0.5	0.1	1	0.4	0.7
25-29	5	1.3	0.2	..	...	...
30-34	12	3.1	0.4	..	...	...
35-39	38	9.8	1.4	..	...	...
40-44	65	16.8	2.7	15	6.4	2.1
45-49	70	18.0	3.6	23	9.9	2.5
50-54	60	15.4	3.4	37	15.9	3.6
55-59	52	13.4	3.9	59	25.3	5.9
60-64	37	9.5	3.5	42	18.0	4.5
65-69	18	4.6	2.2	25	10.7	3.3
70-74	13	3.4	2.3	15	6.4	3.2
75 and over	7	1.8	1.1	15	6.4	3.3
Total	388	100.0	1.1	233	100.0	3.1

* Less than 0.05

100,000. This exceeded the rate for native whites in the ratio of 2.81 to 1. There were only 2 first admissions with general paresis among the foreign whites at ages under 40, both females. The rate rose from 2.1 at ages 40 to 44 to a maximum of 5.9 at ages 55 to 59.

Among foreign-born males the rate rose to a maximum of 9.7 at ages 55 to 59. There was little variation in rates among foreign-born females, because of small numbers. The average rate for females was 1.1, compared with 5.2 for males. The latter was in excess in the ratio of 4.73 to 1, compared with a corresponding ratio of only 1.88 to 1 among native whites. There was a significantly high sex ratio among foreign whites at all ages.

The rate for foreign-born whites exceeded that for native whites in the ratio of 2.82

to 1. The excess was greater among males, the rates being in the ratio of 3.47 to 1. The relative difference was significantly less among females, the rate for foreign females being in excess in the ratio of only 1.38 to 1.

There were few first admissions with general paresis at younger ages among the foreign-born, for example below age 50. Beyond this age, the foreign-born had higher rates than native-born. But this was because of higher rates among foreign-born males. Foreign-born females, on the other hand, had significantly lower rates than native females between ages 40 and 69.

We turn, therefore, to summary rates, adjusted for age and sex proportions, as shown in Table 5. The standardized rate for native whites fell from 7.2 per 100,000 in 1940 to 1.9 in 1950, a reduction of 74 per cent. Males and females both showed

significant decreases during the decade, but the decrease was relatively greater for males. The male rate was in significant excess in both 1940 and 1950, but the sex difference declined in 1950.

The foreign-born had a standardized rate of 8.1 in 1940, compared with 2.0 in 1950, a reduction of 75 per cent. The rates decreased among foreign-born males from 13.3 to 3.1, and decreased among females from 3.4 to 1.0. As with native whites, the decrease was relatively greater among males.

In 1940, the standardized rate for foreign-born whites exceeded that of native whites in the ratio of 1.13 to 1. In 1950, the ratio was 1.05 to 1. Thus, the excess of the rate for foreign-born in 1950 was reduced from 182 per cent on the basis of crude rates to only 5 per cent on a comparable age basis. In fact, foreign-born females, who had a higher crude rate than native females, had a lower rate by 17 per cent when corrected for age differences. The standardized rate for foreign-born males was in excess, however, by 19 per cent. Since syphilis is more widespread in urban than in rural areas, a further correction is necessary in order to correct for the higher degree of urbanization among foreign-born. For reasons explained previously, we shall compare standardized rates for New York City.

It now appears that foreign-born had a standardized rate of 1.9 per 100,000, compared with 2.0 for natives. The rate for foreign-born females was only 77 per cent of that for native females. Among males, the rate for foreign-born was higher by only 4 per cent.

We have concentrated upon average differences between foreign-born whites and native whites. But more significant comparisons may be seen by references to rates among some important groups of foreign-born. Unfortunately, because of small numbers, standardized rates could not be computed for the foreign-born who came from England and Wales, Ireland, Norway and Sweden. Rates were computed, however, for immigrants from Germany, Poland, Russia and Italy. Poland and Russia both showed rates lower than those for all foreign-born. Their rates were also less than those for native whites. The rate for Germany, although higher than that for Poland and Russia, was less than the average for all foreign-born, and less than that for natives. Italian-born had the highest standardized rate, 2.8, but this was due to the relatively high rate of 5.2 among Italian-born males. Comparisons based upon first admissions from New York City point to the same conclusions.

TABLE 5

*Average annual standardized * rates of first admissions with general paresis to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	10.7±0.37	2.6±0.17	0.24	13.3±0.64	3.1±0.34	0.23	1.24	1.19
Females	3.9±0.22	1.2±0.11	0.31	3.4±0.33	1.0±0.19	0.29	0.87	0.83
Total	7.2±0.21	1.9±0.10	0.26	8.1±0.36	2.0±0.19	0.24	1.13	1.05

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

Alcoholic Psychoses

There were 1,976 native white first admissions with alcoholic psychoses during 1949-1951, giving an average annual rate of 5.8 per 100,000 population. The corresponding rate in 1940 was 6.0. The decrease during the decade occurred almost entirely among

There were 741 foreign-born white first admissions with alcoholic psychoses during 1949-1951, or an average annual rate of 9.9 per 100,000, compared with 10.3 in 1940. In general, both sexes showed lower age specific rates in 1950. In that year the rates rose to a maximum of 13.2 at ages 45 to 54. Males

TABLE 6

White first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	..	...	...	..	...	...
15-19	4	0.2	0.2	..	...	...
20-24	13	0.7	0.4	1	0.1	0.7
25-29	68	3.5	2.2	2	0.3	0.8
30-34	139	7.0	4.6	6	0.8	2.4
35-39	250	12.7	8.9	18	2.4	4.2
40-44	365	18.4	14.9	79	10.7	11.7
45-49	358	18.1	18.3	121	16.3	13.2
50-54	285	14.4	16.5	136	18.4	13.2
55-59	246	12.4	18.3	126	17.0	12.6
60-64	147	7.4	14.0	119	16.1	12.9
65-69	76	3.8	9.2	96	13.0	12.9
70-74	19	1.0	3.4	22	3.0	4.7
75 and over	6	0.3	1.7	15	2.0	3.3
Total	1,976	100.0	5.8	741	100.0	9.9

males. The average annual rates for males were 10.4 in 1940 and 9.4 in 1950, whereas they increased among females from 1.8 to 2.4. The decrease occurred among males at almost all ages. However, they increased among females at almost all ages.

The average annual rate increased among native whites in 1950 to a maximum of 18.3 per 100,000 at ages 55 to 59. Among males, the rate increased to 31.9 at ages 55 to 59. The maximum among females, 8.3, was reached at the younger level of ages 40 to 44.

had a maximum rate of 21.9 at ages 50 to 54, but females reached their maximum of 6.3 at ages 40 to 44.

Among both native and foreign whites, the rates were significantly higher for males, the excess increasing with advancing age, especially among native whites.

The crude rates implied a higher incidence of alcoholic psychoses among foreign-born. However, this is a spurious result because of the differing age structures of the two populations. At almost all ages, the rates were lower for the foreign-born, among

TABLE 7

*Average annual standardized * rates of first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	18.9±0.53	16.4±0.46	0.87	13.4±0.66	11.7±0.66	0.87	0.71	0.71
Females	3.1±0.21	4.0±0.22	1.29	3.1±0.34	3.4±0.34	1.00	1.10	0.85
Total	10.7±0.28	9.9±0.24	0.93	8.2±0.34	7.4±0.37	0.90	0.77	0.74

* White population of New York State, aged 20 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

both males and females. (See Table 6.) A more equitable comparison is therefore shown on the basis of standardized rates, adjusted for both age and sex. (See Table 7.)

Among native whites, the standardized rate fell from 10.7 per 100,000 in 1940 to 9.9 in 1950. This was because of a decrease among native males from a rate of 18.9 to 16.4. Among native females, on the contrary, the rate increased from 3.1 to 4.0. Thus, the sex difference in incidence of alcoholic psychoses was reduced during the decade.

Among the foreign-born, the standardized rate decreased from 8.2 in 1940 to 7.4 in 1950, a reduction of 10 per cent. This resulted from a decrease among males from a rate of 13.4 in 1940 to 11.7 in 1950. The rate for females remained unchanged at 3.4 per 100,000. Thus, the relative excess of the male rate was reduced, as with native whites. Although rates for males remained greatly in excess over those for females, there was an implication of a relative increase of alcoholic psychoses among females.

As shown previously, foreign-born whites had lower age-specific rates of first admissions with alcoholic psychoses than native whites. Consequently, the former had a

lower standardized rate. Thus, foreign-born whites had a rate of 7.4 per 100,000 in 1950, compared with 9.9 for native whites, the rate for the latter being in excess by 34 per cent. This is a greater disparity than existed in 1940.

Foreign-born males had a rate of 11.7 in 1950, compared with 16.4 for native whites, the latter being in excess by 40 per cent. Native whites had shown a similar excess in 1940. Among females, however, there was a change from an excess by the foreign-born in 1940 to a reversal in 1950. In 1940, the rate for foreign-born females was in excess by 10 per cent. In 1950, the rate for native females was in excess by 18 per cent.

A further adjustment must be made by considering the effect of urbanization. Because of omissions in the primary data for the whole state, the comparisons will be based upon first admissions from New York City.

In comparison with the whole state, the standardized rate for native whites increased in New York City to 11.3 per 100,000, whereas that for foreign-born whites decreased slightly to 7.3. Consequently, the latter represented only 64 per cent of the rate for native whites. Foreign-born males and females both had lower rates than cor-

responding natives. The rate for foreign-born males represented only 62 per cent of that for native males, compared to a corresponding percentage of 70 among females.

In general, therefore, it is clear that alcoholic psychoses are less prevalent among foreign-born whites in New York State than among native whites. There is great variation, however, when one considers important foreign-born groups. Thus, the highest standardized rate of such psychoses is found among those born in Ireland. Their rate is almost twice that for those born in Norway and Sweden. The lowest rate occurred among Russian-born, who had a rate of 1.6 compared with 7.4 for all foreign-born in New York State, and 9.9 for all native whites. The next lowest rate, 2.4, occurred among Italian-born. Relatively low rates occurred among German-Born (5.1) and Polish-born (4.9). Those born in Russia are primarily Jews; the low rate for Russian-born is therefore another demonstration of

the unusually low incidence of alcoholic disorders among Jews.

Psychoses with Cerebral Arteriosclerosis

There were 5,268 native white first admissions with psychoses with cerebral arteriosclerosis during 1949-1951, with an average annual rate of 15.5 per 100,000 population. The corresponding rate in 1940 was 12.9. Males and females had rates of 16.0 and 15.0, respectively, both exceeding the corresponding rates in 1940.

The average annual rate increased with advancing age to a maximum of 310.6 at ages 75 and over. Generally, age-specific rates for males exceeded those for females, and both sets of rates exceeded corresponding rates in 1940.

In 1940, 13.3 per cent of the foreign-born whites in New York State were aged 65 years and over. In 1950, this age group included 22.3 per cent of the total, compared with only 6 per cent of native whites. Hence,

TABLE 8

White first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 40	..	...	...	..	...	...
40-44	12	0.2	0.4	1	...*	0.1
45-49	17	0.3	0.9	15	0.3	1.6
50-54	120	2.3	7.0	69	1.4	6.7
55-59	323	6.1	24.0	236	5.1	23.6
60-64	721	13.7	68.6	659	14.1	71.3
65-69	982	18.6	119.4	1,038	22.2	139.0
70-74	1,068	20.3	189.9	1,059	22.7	227.8
75 and over	2,022	38.4	310.6	1,583	33.9	349.9
Unascertained	3	0.1	...	6	0.1	...
Total	5,268	100.0	15.5	4,666	100.0	62.3

* Less than 0.05

TABLE 9

*Average annual standardized * rates of first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	73.9±1.82	75.4±0.74	1.02	90.9±2.16	78.7±1.95	0.87	1.23	1.04
Females	53.8±1.48	56.0±1.33	1.04	73.6±2.04	66.3±1.82	0.90	1.37	1.18
Total	65.6±1.19	68.8±1.08	1.04	84.8±1.51	76.3±1.37	0.90	1.29	1.11

* White population of New York State, aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

psychoses associated with advanced age are of special significance among the foreign-born.

Foreign-born whites had a higher rate of such psychoses than natives. Foreign-born males had a rate of 67.3 per 100,000; females had a rate of 57.3. The average for both sexes was 62.3. These rates exceeded the corresponding rates for 1940. In 1950, the rates rose to a maximum of 349.9 at age 75 and over. The relative excess of male rates was greater among natives than among foreign-born.

Table 8 compares the annual rates in 1950 according to nativity. Rates for the foreign-born were in excess at every age. In general, rates for foreign-born females exceeded those for native females in higher ratios than occurred among males.

Because of the relative excess of those of advanced age among the foreign-born, it is necessary to adjust the rates with respect to age composition. Consideration must also be given to the sex proportions. The adjusted rates are summarized in Table 9.

The standardized rate for natives increased from 65.6 per 100,000 in 1940 to 68.8 in 1950. The rate for males advanced from

73.9 to 75.4 during the decade. The rates for females increased from 53.8 to 56.0. Males had significantly higher rates than females.

Rates for the foreign-born decreased in 1950, in contrast to small increases among native whites. The decrease was limited to those under 70 years of age. In 1940, the standardized rate for the foreign-born exceeded that for native whites by 29 per cent. The foreign-born also had a higher rate than natives in 1950, but the excess amounted to only 11 per cent.

Again, we must make a further adjustment with respect to geographical distribution within the state of New York, since the rate of first admissions is correlated with the urban-rural ratio. For this purpose we limited the comparisons to New York City.

In 1950, foreign-born whites in New York City had a rate of first admissions with psychoses with cerebral arteriosclerosis of 80.0 per 100,000 population, compared with 83.2 for native-born whites. Among males, the rate for foreign-born was only 92.4 per cent of that for natives. The rates were equivalent for females.

On the basis of crude rates, foreign-born

exceeded natives by 30.2 per cent. When standardized for sex and age proportions, the excess amounted to only 11 per cent. A further partial adjustment for differences in geographical distribution showed that, in fact, foreign-born had a lower rate of psychoses with cerebral arteriosclerosis than natives.

However, these are average results. Only the Irish-born exceeded the average for native whites. They had an average annual standardized rate of 105.9 for the state and 110.7 for New York City. The lowest rates occurred among Norwegian-born and English-born. Among the remaining groups, the rates varied, in New York City, from 61.2 among German-born to 69.2 among Russian-born. With the exception of the Irish-born, rates for the selected foreign-born groups were all less than the average rate for all foreign-born whites.

Senile Psychoses

There were 3,672 native first admissions with senile psychoses during 1949-1951. The average annual rate per 100,000 popu-

lation was 10.8, compared with 7.7 in 1940. Males and females had rates of 7.9 and 13.5, respectively. Compared with the previous decade, there was an increase among males from a rate of 6.4 to 7.9. The rates for females increased from 8.9 to 13.5. Between 1940 and 1950, the rates decreased among those under age 70, but they increased significantly beyond this age.

Foreign-born white first admissions with senile psychoses totaled 3,468, with an average annual rate of 46.3 per 100,000. Males and females had rates of 37.3 and 55.1, respectively. Rates in 1950 exceeded those for 1940. At all corresponding ages, females had higher rates than males. The sex ratios did not vary with age, however.

With but one exception, rates for foreign-born exceeded those for natives at all ages. Among males, the excess varied from 11 to 40 per cent. In general, rates for foreign-born females exceeded those for native females in greater ratios than those shown by males at corresponding ages.

The crude rate for foreign-born males exceeded that for natives by over 300 per

TABLE 10

White first admissions with senile psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 50	..	...	...	..	...	...
50-54	4	0.1	0.2	2	0.1	0.2
55-59	9	0.2	0.7	10	0.3	1.0
60-64	94	2.6	8.9	98	2.8	10.6
65-69	267	7.3	32.4	315	9.1	42.2
70-74	669	18.2	118.9	690	19.9	148.4
75 and over	2,622	71.4	402.8	2,351	67.8	519.7
Unascertained	7	0.2	...	2	0.1	...
Total	3,672	100.0	10.8	3,468	100.0	46.3

TABLE 11

*Average annual standardized * rates of first admissions with senile psychoses to all hospitals for mental disease in New York State, per 100,000 population among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	34.6±1.24	36.4±1.14	1.05	42.9±1.48	44.8±1.48	1.04	1.24	1.23
Females	37.4±1.24	44.2±1.18	1.18	56.3±1.79	59.4±1.72	1.06	1.51	1.34
Total	39.7±0.92	46.0±0.88	1.16	55.3±1.22	59.9±1.28	1.08	1.39	1.30

* White population of New York State, aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

cent. The excess among females amounted to 300 per cent. The age-specific rates in Table 10 show that this is spurious, however. Therefore, the summary rates were recomputed, with adjustments for age and sex proportions. (See Table 11.)

Among natives, the standardized rate for senile psychoses increased from 39.7 per 100,000 in 1940 to 46.0 in 1950. This was due primarily to an increase among females from a rate of 37.4 in 1940 to 44.2 in 1950. The rate for males increased moderately from 34.6 to 36.4.

Among the foreign-born, the standardized rate increased by 8 per cent during the decade, from 55.3 to 59.9. Rates for females exceeded those for males during both years, but the relative excess of the former remained constant. Among native whites, the relative excess of the female rate increased during the decade from 8 to 21 per cent.

In 1940, the rate for the foreign-born exceeded that for natives by 39 per cent. The excess was greater for foreign-born females than for males. In 1950, the foreign-born again had higher standardized rates than natives, but the excess was reduced to 30 per cent. The reduction was marked among females.

The comparisons are still spurious, how-

ever, because they do not take the factor of size and density of population into consideration. The foreign-born have a larger proportion living in an urban environment, especially in New York City. A further standardization consists, therefore, in limiting the comparison to New York City.

Instead of an excess, we now find that foreign-born and native-born had almost equal rates of 63.1 and 64.9, respectively. The contrast is especially marked among males, the foreign-born having a rate of 43.1 compared with 47.4 for native-born.

The comparison, based upon crude rates, began with an excess on the part of foreign-born of over 300 per cent. This was spurious because of the age factor. Standardization with respect to age reduced the excess to 30 per cent. When size and density of population were taken into consideration, we found a reversal in the trend of comparison, foreign-born having, in fact, a lower rate, although the difference was not statistically significant.

The highest rate, 76.2, occurred among Irish-born. This exceeded the rates for all foreign-born and for native-born. Norwegian-born and Swedish-born followed with rates of 69.9 and 69.3, respectively. The lowest rate occurred among Polish and Rus-

sian-born, which may be attributed to the large proportions of Jews in these two groups. This confirms results shown in earlier studies.

Involuntional Psychoses

There were 2,680 first admissions with involuntional psychoses among native whites during 1949-1951, or an average annual rate of 7.9 per 100,000 population. Males and females had rates of 4.8 and 10.8, respectively. These represent significant increases in comparison with corresponding rates in 1939-1941. The rates increased to a maximum of 44.1 at ages 55 to 59. In general, rates for females were well in excess of those for males. Among females, they rose to a maximum of 56.1 at ages 50 to 54.

Foreign-born whites had an average annual rate of 29.3, exceeding that for natives in the ratio of 3.71 to 1. Males and females had corresponding rates of 19.4 and 39.1,

respectively. Both were in significant excess over corresponding rates for natives. The rate for foreign-born reached a maximum of 57.5 at ages 50 to 54.

Compared with corresponding rates during 1939-1941, there were significant increases. The male rate increased from 9.0 to 19.4; the female rate increased from 24.1 to 39.1. The total rates increased from 16.4 to 29.3.

With minor exceptions among males at advanced ages, foreign-born whites had higher rates than natives at corresponding ages. (See Table 12.) Generally, the relative excess was greater among females. But among both sexes, the relative excess of the rates for foreign-born decreased with advancing age.

The ratios of the age-specific rates show that the great excess of the crude rates among foreign-born was in part spurious, and resulted from differential age distri-

TABLE 12

White first admissions with involuntional psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 25	..	...	...	..	...	...
25-29	1	...*	...*	..	...	...
30-34	5	0.2	0.2	6	0.3	2.4
35-39	51	1.9	1.8	17	0.8	4.0
40-44	312	11.6	12.8	124	5.6	17.8
45-49	515	19.2	26.3	367	16.7	40.1
50-54	692	25.8	40.1	595	27.1	57.5
55-59	594	22.2	44.1	549	25.0	54.9
60-64	323	12.1	30.7	362	16.4	39.1
65-69	147	5.4	17.9	148	6.7	19.8
70-74	35	1.3	6.2	26	1.2	5.6
75 and over	5	0.2	0.8	4	0.2	0.9
Total	2,680	100.0	7.9	2,198	100.0	29.3

* Less than 0.05

TABLE 13

*Average annual standardized * rates of first admissions with involutional psychoses to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	9.8±0.51	14.4±0.56	1.47	9.7±0.60	17.9±0.86	1.84	0.99	1.24
Females	20.4±0.72	29.0±0.74	1.42	28.4±1.07	42.0±1.31	1.48	1.39	1.44
Total	14.8±0.44	21.4±0.47	1.44	18.8±0.60	29.5±0.78	1.57	1.27	1.38

* White population of New York State, aged 35 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

butions. Rates adjusted for both age and sex proportions are therefore summarized in Table 13.

The standardized rate among native whites increased from 14.8 in 1940 to 21.4 in 1950, an increase of 44 per cent. Males and females both showed significant increases during the decade.

Rates increased more rapidly among the foreign-born. They advanced by 57 per cent, from 18.8 in 1940 to 29.5 in 1950. The increase was relatively greater among males than among females.

On the basis of crude rates, it appeared that the rate for foreign-born exceeded that for native-born by 200 per cent. On the basis of standardized rates, it is clear that much of the excess was due to selection by age. In 1940, the rate for the foreign-born was in excess by only 27 per cent. However, this increased to an excess of 38 per cent in 1950. The relative disparity between foreign-born and native-born was greater for females than for males.

A further adjustment is essential with respect to the urban-rural divisions of the populations. The involutional psychoses are more frequent in urban areas, and are especially frequent in New York City. Since a higher proportion of foreign-born were

living in New York City, rates of first admissions may be computed for the metropolis and thereby eliminate, in large part, the bias resulting from the urban-rural disparity.

On this basis, we obtained an average annual standardized rate of 31.1 per 100,000 for foreign-born and 24.6 for native-born. The former is in excess by 26 per cent. The disparity is still significant, although less than that for the state. The excess was especially marked among females.

Although foreign-born whites had a higher average standardized rate of involutional psychoses than native whites, there were two foreign-born groups that departed from this trend. Swedish-born, living in New York City, had a rate of 18.9 per 100,000. Italian-born had a rate of 19.1. Polish-born had a high rate of 38.7, followed by Irish-born with a rate of 34.4. Russian-born, largely Jewish, had a rate of 31.4, which was on a par with that for all foreign-born, but in excess of that for native-born whites.

Manic-Depressive Psychoses

First admissions with manic-depressive psychoses have been decreasing in frequency. During 1939-1941 there were 2,455

TABLE 14

White first admissions with manic-depressive psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	3	0.2	...*	..	...	...
15-19	50	2.8	2.0	3	0.6	4.2
20-24	164	9.3	5.8	12	2.3	8.1
25-29	211	12.0	7.0	26	5.0	10.3
30-34	237	13.4	7.9	25	4.8	10.3
35-39	278	15.8	9.9	42	8.1	9.8
40-44	263	14.9	10.8	73	14.0	10.4
45-49	171	9.7	8.7	77	14.8	8.4
50-54	134	7.6	7.8	89	17.1	8.6
55-59	105	6.0	7.8	63	12.1	6.3
60-64	77	4.4	7.3	50	9.6	5.4
65-69	40	2.3	4.9	41	7.9	5.4
70-74	22	1.2	3.9	17	3.3	3.7
75 and over	7	0.4	1.1	3	0.6	0.7
Total	1,762	100.0	5.2	521	100.0	7.0

* Less than 0.05

such first admissions among native-born whites, with an average annual rate of 8.2 per 100,000 population. Despite a growth of the general population, there were only 1,762 such first admissions during 1949-1951, or an average annual rate of 5.2. Males and females both shared in the decrease. The rate for native white males decreased from 5.3 to 3.5; that for females decreased from 11.0 to 6.7.

In 1950, the average annual rates rose to a maximum of 10.8 at ages 40 to 44. With a few minor fluctuations, rates for females were generally in excess of those for males. The rates rose among females to a maximum of 13.2 at ages 35 to 39. They reached a maximum of 8.3 among males at ages 40 to 44.

Foreign-born whites showed a similar de-

crease in the number of first admissions with manic-depressive psychoses. The number declined from 930 in 1939-1941 to 521 in 1949-1951. The corresponding average annual rates were 10.8 and 7.0, respectively.

During 1949-1951, average annual rates rose among foreign-born males to a maximum of 8.2 at ages 40 to 44. Foreign-born females reached a maximum of 16.4 at ages 35 to 39.

Rates were higher among females, but in general, the relative excess decreased with advancing age.

At younger ages (i.e., under 35), foreign-born whites had higher rates than native-born. Beyond 35, however, the trend changed, and native-born had higher rates. On the basis of crude rates, the foreign-born were in excess by 34 per cent. The

relative excess was especially high for foreign-born males. Examination of the age-specific rates shows that the excess resulting from crude rates is spurious, in part. Therefore, it was necessary to make the comparison on the basis of a standard age and sex distribution. (See Table 15.)

We may note first that standardized rates of first admissions with manic-depressive psychoses decreased among both native and foreign-born whites at approximately the same rate. Among native whites they declined from 11.3 in 1940 to 7.1 in 1950. Among foreign-born whites they declined from 12.2 to 7.7.

In both years, the rates for foreign-born exceeded those for native-born by 8 per cent. This is in marked contrast to a relative excess of 34 per cent in 1950 on the basis of crude rates. On the basis of standardized rates, native-born males had a higher rate than foreign-born males by 6 per cent. Foreign-born females had a higher rate, however. Their excess over native females increased from 11 per cent in 1940 to 18 per cent in 1950.

As for preceding groups of mental disorders, we may adjust still further by limit-

ing comparisons to New York City. This will give an approximation to standardization with respect to urban-rural differentials.

On this basis, the difference in rates between the two populations was reduced to 4 per cent. Native-born and foreign-born had rates of 7.3 and 7.6, respectively. The difference is not statistically significant. Among males, the rate for native-born was in excess by 21 per cent. Among females, on the contrary, the rate for foreign-born was higher by 14 per cent. For practical purposes, we may conclude that there were no significant differences in the incidence of manic-depressive psychoses among native and foreign-born.

These are average results, however, and differences may be found within selected groups of foreign-born. Thus, Russian-born and Polish-born, living in New York City, had higher rates than either native or all foreign-born. Since these populations are largely Jewish, it may be concluded that Jews have rates of manic-depressive psychoses above the average. Italian-born, on the other hand, had a rate of 4.8, which was below the average. The rate for Irish-born

TABLE 15

*Average annual standardized * rates of first admissions with manic-depressive psychoses to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	7.7±0.31	5.1±0.24	0.66	7.4±0.48	4.8±0.42	0.64	0.96	0.94
Females	14.8±0.42	9.0±0.31	0.61	16.5±0.74	10.6±0.62	0.64	1.11	1.18
Total	11.3±0.26	7.1±0.20	0.63	12.2±0.44	7.7±0.38	0.63	1.08	1.08

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

may be considered average. It is probable that Swedish-born and Norwegian-born both had relatively low rates.

Dementia Praecox

Native white first admissions with dementia praecox increased in number from 7,477 during 1939-1941 to 11,671 during 1949-1951. The corresponding average annual rates increased from 24.9 per 100,000 to 34.3. The rates increased among native-born males from 26.1 to 35.0; the corresponding rates for native-born females were 23.8 and 33.7. The rates increased substantially at all ages.

The rates rose rapidly in 1950 to a maximum of 79.5 per 100,000 at ages 20 to 24. The maximum rate for males, 99.0, occurred at ages 20 to 24. Females reached a maxi-

mum of 72.2 at ages 25 to 29. Rates for males exceeded those for females through ages 25 to 29.

Rates for foreign-born whites declined between 1940 and 1950, in contrast to an increase among natives. Foreign-born males had rates of 28.7 and 25.6 in 1940 and 1950, respectively. Corresponding rates for foreign-born females were 32.8 and 31.3, respectively. Total foreign-born had rates of 30.7 and 28.4, respectively. As with native-born, rates for males exceeded those for females below age 29, but were generally lower at subsequent ages.

In general, rates for the foreign-born exceeded those for natives at corresponding ages. The relative differences were greatest under age 35. This was true especially of males, among whom the rates were actually

TABLE 16

White first admissions with dementia praecox to all hospitals for mental disease in New York State, 1949-1951, classified according to nativity and age

Age (years)	Native			Foreign-born		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	202	1.7	2.2	4	0.2	3.5
15-19	1,143	9.8	46.4	62	2.9	87.4
20-24	2,245	19.2	79.5	164	7.7	110.4
25-29	2,331	20.0	77.0	252	11.8	99.7
30-34	1,982	16.6	64.1	182	8.5	75.2
35-39	1,573	13.4	56.3	271	12.7	63.0
40-44	1,005	8.6	41.1	341	16.0	48.9
45-49	576	4.9	29.4	309	14.5	33.7
50-54	332	2.8	19.2	221	10.4	21.4
55-59	187	1.6	13.9	165	7.7	16.5
60-64	86	0.7	8.2	94	4.4	10.2
65-69	42	0.4	5.1	38	1.8	5.1
70-74	6	0.1	1.1	13	0.6	2.8
75 and over	8	0.1	1.2	10	0.5	2.2
Unascertained	3	...	...	5	0.2	...
Total	11,671	100.0	34.3	2,131	100.0	28.4

* Less than 0.05

TABLE 17

*Average annual standardized * rates of first admissions with dementia praecox to all hospitals for mental disease in New York State, per 100,000 population, among native and foreign-born whites*

	Native (a)			Foreign (b)			Ratio (b) to (a)	
	1940	1950	Ratio	1940	1950	Ratio	1940	1950
Males	29.0±0.60	41.8±0.70	1.44	41.2±0.36	57.2±1.46	1.39	1.42	1.37
Females	27.8±0.58	40.6±0.65	1.46	37.5±1.11	50.3±1.36	1.34	1.34	1.24
Total	28.4±0.42	41.3±0.48	1.45	39.4±0.80	52.7±0.99	1.28	1.39	1.28

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

lower among the foreign-born in middle life. Among females, the relative differences were also high at younger ages; but the disparity remained high at older ages.

On the basis of crude rates, the foreign-born had lower rates of dementia praecox than native whites. This is spurious, however, arising from the more favorable age distribution of the foreign-born with respect to this disorder. The age specific rates, on the contrary, were higher for foreign-born. Hence, it is necessary to compare standardized rates, as shown in Table 17.

We may note first an increase among natives from a standardized rate of 28.4 in 1940 to 41.3 in 1950, an increase of 45 per cent. Males and females both showed significant increases during the decade. In neither year was the sex difference significant.

The crude rates indicated an apparent decrease among the foreign-born between 1940 and 1950. This was due to the different age distributions during these periods. On a comparable basis, the standardized rates increased among foreign-born from 39.4 to 52.7. Among males, they increased from 41.2 to 57.2. The corresponding rates for females were 37.5 and 50.3, respectively.

The standardized rates for 1940 indicated

a higher rate for the foreign-born by 39 per cent. In 1950, the excess was reduced to 28 per cent.

Rates of first admissions with dementia praecox are not uniform throughout the state, but are higher in urban than in rural areas, and are especially high in New York City. Rates for foreign-born are weighted by their greater proportion living in the metropolis. An approximation to further standardization may be achieved by limiting comparisons to New York City.

Foreign-born had a standardized rate of 56.6 per 100,000, compared with 48.9 for native whites, an excess of 16 per cent. Foreign-born males and females both had higher rates than native-born, the excess being greater among males.

Thus, an excess of 21 per cent by native-born, based upon crude rates, was reversed to an excess by foreign-born, when consideration is given to age and sex proportions of the populations, and to degree of concentration in urban areas.

Those born in England and Wales had a lower rate than all foreign-born, and they also had a significantly lower rate than native-born. Swedish-born had the highest rate in New York City, contrasting with the low rate of 30.5 among Norwegian-born.

The rate for Italian-born was equivalent to that for natives. Irish and German-born both had rates above the average. The rate was especially high among Polish-born.

SUMMARY

This is a study of rates of mental disease among the native and foreign-born white population of New York State. The data consist of statistics of first admissions to all hospitals for mental disease in New York State from October 1, 1948, to September 30, 1951. The midpoint of this period, April 1, 1950, coincided with the date of the census of population, and thus permitted the computation of average annual rates of first admissions. There were 35,317 native-born first admissions and 16,020 foreign-born first admissions during this period. The average annual rates per 100,000 population were 103.9 and 213.8, respectively, the latter being in excess in the ratio of 2.06 to 1.

However, this ratio is spurious, because of the greater proportion of those of middle and advanced age among the foreign-born, which increased their rate of first admissions disproportionately. When the rates were compared on a common age basis, they became 152.0 for native-born and 178.7 for foreign-born. That ratio of the rates was reduced to 1.18 to 1.

But rates of first admissions are also influenced by the degree of urbanization. Foreign-born live in a higher proportion in urban areas, which have higher rates than rural areas.

For reasons given previously, it was impossible to make a comparison between native and foreign-born whites in 1950, holding the environmental distribution constant. The best approximation in the circumstances was to limit the comparison

to New York City, and to standardize the rates with respect to age and sex. On this basis, the standardized rates became 168.8 for native-born and 183.3 for foreign-born, an excess of only 9 per cent by the foreign-born.

Similar comparisons may be made for the major diagnostic groups, using standardized rates for the native and foreign-born white populations of New York City.

There was no significant differences in rates of first admissions with general paresis among native and foreign-born males, the rates being 2.8 and 2.9 per 100,000, respectively. Foreign-born females had a lower rate than native-born females.

With respect to alcoholic psychoses, rates were significantly lower for the foreign-born. They were 7.3 and 11.3 per 100,000 for foreign and native-born, respectively.

Standardized rates of first admissions with psychoses with cerebral arteriosclerosis were 80.0 for foreign-born and 83.2 for native-born, but the difference is not statistically significant.

Similarly, with respect to senile psychoses, the rate was lower for foreign-born than for natives, although the difference is not significant.

Thus, comparisons between native and foreign-born do not reflect unfavorably upon the latter, when limited to mental disorders of organic origin. There is a difference, however, when one considers so-called functional disorders, which have a more definite relation to inherent personal characteristics. Thus, foreign-born had a standardized rate of 31.1 for involutional psychoses, compared with 24.6 for native-born. Foreign-born had a slightly higher rate with respect to manic-depressive psychoses. Their rate for dementia praecox was significantly higher than that for native-born, by 16 per cent.

It is generally believed that differences in rates of general paresis or alcoholic psychoses, in so far as they relate to populations, arise from environmental causes, as for example, the differential spread of syphilis. Opinions differ, however, with respect to functional disorders, especially dementia praecox. There is a belief that emigrants include a proportion of psychopathic personalities higher than is found among non-migrating populations. There is some support for this, derived from the data for

internal migration. But to answer this question properly with respect to international migrants requires an international system of reporting mental disorders, similar to that employed for the reporting of physical diseases. Unfortunately, it is not yet possible to make such comparisons on a sound basis with respect to mental disease. Therefore, at present we can only speculate on interpretations as to the possible constitutional differences between migrating and non-migrating populations.

Book Reviews

SENILE DEMENTIA: A CLINICAL, SOCIOMEDICAL AND GENETIC STUDY

By Tage Larsson, Torsten Sjögren and
George Jacobson

Copenhagen, Denmark, Munksgaard, 1963, 259 pp.

This comprehensive report on the histories and family backgrounds of 377 verified cases of senile dementia, ascertained with the co-operation of the two largest mental hospitals in Stockholm, is typically Scandinavian in its approach (conservative), scholarship (solid), format (drab) and documentation (meticulous).

The study covered 2,675 persons who belonged to 256 fully investigated family units (parents, siblings, spouses and children) and was supported by both the Swedish Medical Research Council and the United States Public Health Service.

The magnitude of the social and clinical problems which prompted this investigation seemed to be reflected by the fact that in the period 1930-1960, the proportions of aging men and women in the Stockholm population (over 65 years of age) increased by 186 per cent and 150 per cent respectively, although the total population of the city increased only by 61 per cent during the same period. In line with these trends, it was estimated that nearly 23 per cent of all mental hospital patients in Stockholm would be expected to fall into the diagnostic categories of senile dementia or arteriosclerotic psychosis in 1975.

The results of the genetic analysis largely confirmed the findings of earlier investigators, especially those obtained by means of the twin study method. While the relatives of index cases (hospital patients with

senile dementia) showed a significant increase in their age-corrected expectancy rate for this disorder, no appreciable increase was observed either in other risks of psychiatric interest (psychoses other than senile dementia) or in the later need of hospitalization in that group of senescent persons who were known to have recovered from another type of psychosis at an earlier age. In the sibships of the index cases, the senile dementia risk was found to be 4.3 times greater for the patients' brothers and sisters than for their contemporaries in the general population.

The question as to the usual mode of transmission of the genetic factor or factors operating in the etiology of "essential" senile dementia (clinically assumed to be clearly distinguishable from both Alzheimer's disease and simple senility) has been left in abeyance by the investigators, if only because their data are regarded as being compatible with a single factor as well as with a multifactor type of inheritance. In fact, the authors emphasize that the genetic theory of the essential form of senile psychosis (Roth) "does not exclude the possibility that senile dementia is sometimes conditioned by exogenous factors, but presumably by factors that are connected with the physiological process of aging and not with the sociomedical environment."

Having failed to obtain "any indications that environmental factors of a sociomedical nature play a part in the onset of senile dementia," the authors compare its etiology to that of Huntington's chorea or essential tremor, stressing the need for extensive biochemical family studies in all these disorders.—LISSY F. JARVIK, M.D., and FRANZ J. KALLMANN, M.D., New York State Psychiatric Institute, New York, N. Y.

SUICIDE: A SOCIOLOGICAL AND STATISTICAL STUDY

By Louis I. Dublin

New York, The Ronald Press, 1963, 240 pp.

Thirty years have passed since Dr. Louis I. Dublin and Bessie Bonzell published *To Be or Not To Be: A Study of Suicide*, which was to become something of a minor classic. Now, the senior author has updated and revised this volume. The present edition is an abbreviated but more compact book.

Although it is subtitled *A Sociological and Statistical Study*, it cuts across many discipline lines: anthropology and comparative religion, philosophy and law, psychology and demography. It makes no pretension at probing suicide in depth in any of these areas, but enough content is presented wisely and interestingly to stimulate the reader to thought, to question, and occasionally even to argument. Like its predecessor, this volume serves the dual purpose of a source book and as a stimulant to the individual as well as the collective conscience concerning the tragedy of suicide, which in the United States, expresses itself in an estimated 25,000 deaths and in several hundreds of thousands more attempts each year. Their rippling effects reach out and touch all of us in one way or another.

The literature on suicide in the United States is relatively sparse. Research is relatively lean. Many disciplines including psychiatry and preventive medicine are only sparsely represented in the ranks of active and productive investigators.

Dr. Dublin has been among the leaders who have tried to stir professional groups to an awareness of the urgent and continuous need for more research on suicide and the national conscience to the need for that sympathetic recognition of the problem

which makes management and control possible.

In the period between the publication of the two editions the medical profession has begun to view suicide not as an end-product but as a process with diagnostic and prognostic signs, as well as with potentials for reversibility. The new edition serves to keep these concepts in the forefront of our consciousness.—JOSEPH HIRSH, Albert Einstein College of Medicine, Yeshiva University, New York, N. Y.

THE EMPLOYED MOTHER IN AMERICA

By F. Ivan Nye and Lois W. Hoffman

Chicago, Rand, McNally & Co., 1963, 406 pp.

The employed mother is a permanent and significant addition to the familial and economic structure of American society. A major objective of this book is to gather current research on the subject of maternal employment. Implied in this aim is a commitment to the advancement of research. It attempts to present selected findings in sociopsychological research completed from 1957 to early 1962.

The book is organized in four sections. Part I serves as a broadly introductory function in presenting the basis for the emergence of the employed mother as a major phenomenon in American life—its cultural, social, sociopsychological and psychological rationale. This includes differences between mothers in and outside the labor force. Part II presents rather extensive research dealing with the children of employed and nonemployed mothers. Part III compares the marital relationships of employed and nonemployed women. Part IV compares the self-feelings, health and relationships of employed and nonemployed mothers.

It is the authors' view that cultural

change has allowed mothers increased free time, has added incentive, and simultaneously has provided extensive employment opportunities. By this is meant that the employment opportunities outside the home and the awareness of lack of economic productivity in their home, in combination, present strong psychological pressure for many women to enter employment. For example, early marriage with the present median age of 20 years at marriage and the possibility of childbearing completed at age 26 might produce a mother who sees her last child enter school when mother is only 32.

However, with respect to family ideology the authors admit that male dominance still appears to be accepted by most American families. But these authors suggest that a "person-centered" philosophy which includes the needs of the mother as well as the child, is compatible with the status of the employed mother. They reject the "child-centered family" thesis.

Statistical facts in the year 1958 report 22 million women aged 14 or over in the labor force; of these slightly more than half were married. This means that almost two in five households, with children under 18 years, have working mothers. Employed mothers tend to have somewhat more education than mothers not in the labor force. Census data of 1959 also show a higher proportion of non-white (46.2) in the labor force than white (34.8). Ages 25 to 54 are the peak period for employed mothers.

The American mother moved into paid employment in significant numbers during World War II. Contrary to expectations, this continued in the post-war period. This massive movement into employment was made possible by:

1. New labor-saving machinery in the home
2. New inventions and distributive techniques in industry and trade which permitted the mother's economic tasks to be performed more efficiently outside the home

3. Smaller families

4. The spread of equalitarian family ideology

The continued dominance of the value of an increased standard of living provided strong positive motivations for maternal employment. However, personality motives, such as needs for achievement, power, independence and social contact, and monetary motives were found to be interrelated. For example, these authors found that the common supposition that married women are working "for the money" does not tell the whole story. It was found that these women appreciate the regularity and order which work commitment brings. Volunteer activities do not always require this. It was found, however, that women who work because "the family needs money" have the lowest educational attainment of all women studied.

Findings are reported on various aspects of maternal employment. For example in Part II, children of employed and nonemployed mothers were compared. An attempt was made to observe differences in children of working and nonworking mothers. Using matched pair design, no differences were found with respect to dependence and independence. From such data on these children studied (three months in kindergarten; no siblings over 14; born in United States, intact family) maternal employment per se was not found to be the overwhelmingly influential factor in children.

Further it found that partial separation of child and mother (due to mother's employment) was not necessarily damaging to children studied. Studies suggested that maternal employment has a different effect on the mother-child relationship and on the child's behavior, depending on whether or not the mother enjoys working. But it recommends more research, wisely asserting that the jump between maternal employment and child behavior is too broad to be covered in one leap. More research is also

suggested on the personality characteristics of children of working mothers. However, on the basis of current findings, these authors state that employment per se cannot be considered an index of maternal deprivation having detrimental effects on the development of children.

For example, research reported showed no significant relationships between maternal employment and attitudes of mothers toward childrearing (preschool, elementary, adolescent) at any of these three stages. For the adolescent, in tests of school performance, psychosomatic symptoms and affectional relationship to mother appear unrelated to the employment status of mother. However, sex differences were found. Thus the kind of woman who assumes an occupational role through desire for some self-realization exerts an influence on her daughter's development through a modeling process in which the girl identifies with and incorporates many of her mother's ego characteristics.

In summary, research findings reported by these authors since 1952 challenge the view that maternal employment had bad effects on children. They state, rather, that maternal employment does affect the child, but that such effects may be good, bad or incapable of evaluation and may depend on a multitude of interrelated considerations. In Part III these authors suggest more research in the area of husband-wife relationship, family variables, personality development and maternal mental health.

Employment as a test variable of socioeconomic status fails to disclose any statistically significant relationships between employment status and marital adjustment. Research reports do reveal that more marital conflict is present among couples in which mother is employed. Also a slightly higher proportion of employed mothers studied have at some time been divorced. Also that professionally employed women

appear to be more satisfied than women working in nonskilled tasks. However, this appears to be due to the fact that women in higher economic brackets also have more labor-saving devices and often housekeepers and are, therefore, less physically tired.

Division of labor is expected to shift when the wife is employed, but does not always exist. The authors admit that the impact of the wife's employment on the couple's evaluation of their marriage is least understood. Nothing is known about male evaluations of the marital relationship. Employed wives as a whole do not differ appreciably from housewives in their evaluation of their marriages. However, there appears to be positive evaluations associated with work in low-income households and negative evaluations when the husband's income is high.

Part IV deals with self-feelings, health and relationships. With respect to maternal mental health, the primary analysis of the relationship between employment and anxiety symptoms fail to disclose that employed mothers in the general population had more psychosomatic symptoms than nonemployed mothers. For working mothers, feelings of adjustment per se were independent of employment status. Of 19 indices of felt distress analyzed, only 4 were found to be correlated with employment status.

With respect to adjustment of mothers to their children, some significant differences (not great) showed better adjustment to children among employed mothers. But other factors such as size of family, etc., may be related, but were not analyzed. Working mothers were found to do less informal visiting in their neighborhood and community and to perform fewer leadership tasks. As for the employer-employee relationship of married mothers, these authors suggest that modifications stemming from employment occur in the family role rather than in the employee role.

In summary, the working mother is in-

volved in a complex role in which social-cultural and economic factors are interrelated. If her work role as a provider is compatible with other roles she plays, it may be positive; if not, negative results are expected. However, since the American working mother is a permanent and significant addition to our labor force, these authors have effectively pointed out relevant findings to reveal her status. In their professional judgment, further research, without bias, is urgently needed to aid in this essential task of understanding her needs and contribution to the labor force and to society. This book has made a substantial step in the pursuit of data which would reveal "what is" maternal employment rather than parade myths. Perhaps others can continue this essential task.—JUANITA LUCK COGAN, PH.D., Young Women's Christian Association, Trenton, N. J.

WORKING WITH CHILDREN IN HOSPITALS: A GUIDE FOR THE PROFESSIONAL TEAM

By Emma N. Plank, with the assistance of Marlene A. Ritchie

Cleveland, Western Reserve University Press, 1962, 86 pp.

"Someone must defend the child against the system," said a pediatrician in referring to the increasingly impersonal attitudes in hospitals brought about by specialization, fragmentation of care, multiplication of diagnostic and therapeutic procedures, and shortages of nurses.

Mrs. Emma Plank has risen to the defense of hospitalized children in a superb way in her book *Working With Children in Hospitals*. To aid children with the problems of separation from home and parents, anxiety about mutilation of their bodies, increased dependency, pain, and immobiliza-

tion, the Cleveland Metropolitan General Hospital established a Child Life and Education Program on its pediatric service, directed by Mrs. Plank. From her understanding of child development and her experience in this unit, she has described and documented many effective, practical, and imaginative methods for helping children cope with the crises of hospitalization.

Separate chapters focus on hospital admission, preparation for and reactions after surgery, play, learning, and the scope of the child care program. The difficult problem of death on the children's ward is handled with understanding of its differing implications for each child, and with the need of children to be told in an appropriate time and way of a death, which they generally sense. When children trust adults, they can express their fears and questions in a manner that enables them to receive acceptance, information and reassurance in helpful ways.

Many constructive activities are described, suitable for hospitalized children of various ages and differing degrees of illness and immobilization. This program is not mere diversion. It is an application of psychologically and educationally sound principles and techniques to helping a child understand, work through and master his difficult experience at a level appropriate to his age and stage of development. Such assistance enables the child to turn from a psychologically crippling passivity to activity which permits him to mature through the mastery of the difficulties encountered in hospitalization.

Who is a child care worker? She is defined as a member of the clinical team who works with children at play, at mealtime, or in hospital school, but who is not involved in nursing care. Ideally she has had training and experience in child development, education and the use of crafts. Yet

many of the principles and techniques described in this book can be applied by other members of the professional team. For instance, texts and anatomical diagrams are included, which may be very useful to physicians, nurses or teachers who have the opportunity and responsibility for preparing children and their parents for hospitalization and surgery.

This book is attractive, well-organized, and fascinating to read. Of special interest and value are vignettes of actual experiences and discussions with child patients. Mrs. Plank's program of child life and education is imaginative and creative, and is serving as a model for many other pediatric services throughout the country. This record of experiences gained and practices evolved may be of inestimable help to pediatricians, surgeons, nurses, hospital administrators, occupational and recreational therapists, and present and potential child care workers, and through them to the children themselves.—**MARTHA LEONARD, M.D.**, Child-Study Center, Yale University, New Haven, Conn.

**THE SOCIOLOGICAL REVIEW
MONOGRAPH NO. 5: SOCIOLOGY
AND MEDICINE—STUDIES WITHIN
THE FRAMEWORK OF THE
BRITISH NATIONAL HEALTH
SERVICE**

Edited by Paul Halmos

*Keele, Staffordshire, England, University of Keele,
1962, 222 pp.*

The eleven articles presented in this monograph, which describe social science studies of various aspects of the British National Health Service, are so varied in scope that there is something of interest for almost any reader; six of the articles, moreover, are directly concerned with mental health.

The effect of psychosocial factors upon

the hospitalization experience both of the mentally and the physically ill receives attention. "A Comparative Clinical and Social Survey of Three Mental Hospitals," which suggests that severe poverty of speech, muteness, and social withdrawal are related to hospital restrictiveness, will attract the attention of persons interested in the therapeutic value of institutional flexibility. In "Hospital Attitudes and Communications," R. W. Revans shows the significant statistical correlation, for 15 acute general hospitals, between a stable and qualified ward staff and decreased length of patient stay on general medical and general surgical wards. The data are followed by a discussion, applicable to all types of hospitals, of the role played by attitudes and communication in retaining or failing to retain such a staff.

Institutional care is the subject of still another article, "Some Medical and Social Characteristics of Elderly People Under State Care." A comparison of persons over 65 years admitted for the first time to geriatric wards, mental hospitals, and welfare homes in Newcastle-on-Tyne revealed that mentally deteriorated patients were frequently accommodated on geriatric wards, while physical illness short of complete incapacitation was a severe problem in mental hospitals. Selection of patients for the three types of facilities appeared somewhat haphazard. Closer integration of medical services for the aged was recommended by the authors, with psychiatrists available to help the nursing staff on geriatric wards and with geriatricians paying regular visits to assist the mental hospital staffs.

The problem of co-ordination, illustrated by the above study, is the theme of an extended analysis in "Changing Roles and Co-ordination of Mental Health Services" by M. W. Susser of the Department of Social and Preventive Medicine, University of

Manchester. From his case study of an industrial area, Professor Susser concludes that recent, sharp changes in attitudes and policies, reallocation of functions, and the development of new functions have produced strains that are reflected in severe discontinuities in patient care. One of these strains results from the expectation of the National Health Service that general practitioners play a larger role in the treatment or considered referral of patients with emotional difficulties than medical training has prepared them to undertake. So important is this subject that the article "The Attitudes of General Practitioners to Psychiatry" is exclusively devoted to it.

Throughout the monograph frequent reference is made to American studies. The most extensive citation is in "Sociological Studies of Psychiatric Outpatient Service," where G. M. Carstairs and J. G. Bruhn describe the relationship between patients' initial role conceptions and the length and success of their therapy and also the relationship between patients' initial role conceptions and their social class membership, as revealed in investigations (in which Dr. Bruhn participated) at the Psychiatric Outpatient Clinic, Grace-New Haven Community Hospital in New Haven, Conn. The authors then discussed the applicability of these findings to psychiatric outpatient clinics in Great Britain.—ESTHER LUCILE BROWN, PH.D., San Francisco, Calif.

THE MEANING OF PSYCHOTHERAPY IN THE TEACHER'S LIFE AND WORK

By Arthur T. Jersild and Eve Allina Lazar, with Adele M. Brodtkin

New York, Bureau of Publications, Teachers College, Columbia University, 1962, 151 pp.

The information gleaned by the authors results from a study of more than 200

teachers who had undergone fairly intensive treatment, ranging from psychoanalytically oriented psychotherapy to formal psychoanalysis. The study also included the same number of teacher controls who had not received any kind of therapy.

An important area of interest was to what degree increased self-understanding could assist or predispose the treated teachers to guide their students toward the attainment of increased self-knowledge, thereby eventuating in a more effective and authentic use of themselves and an increased ability to deal with personal problems.

Throughout this study the preponderance of emphasis seems to be placed upon self-understanding rather than on reconstruction of such characterological attitudes that might spontaneously carry over into a more creative involvement with life.

Both the treated and control groups presented the research workers with answers to such questions as would reveal any significant changes in their attitudes over a four-year period. This included ways of dealing with problems of anger, competition, anxiety and acceptance of self and others. Much of the focus was placed upon internal re-evaluations, a sense of freedom of expression and attitudes toward work rather than external changes which are ordinarily judged by others. Behind this inquiry there was some thread of continuity as to what degree the teachers availed themselves of the countless opportunities to bring out the personal relevance of academic content to their pupils so that learning may have some depth of personal significance to the pupil.

In essence, the group of analyzed teachers became alerted to a much greater degree of self-objectivation than did the controls. They became more circumspect in the conduct of their personal affairs and increased their sensitivities, including their empathy

in dealing with students and colleagues. Their need to exploit the teaching situation in order to appease inappropriate inner needs became appreciably diminished. There were also many other positive by-products of therapy.

It was also noted that a large number of treated teachers continued to experience varying degrees of stress and conflict in approaching the teaching of subject matter with accent on deeper personal involvement, rather than a relatively detached approach. It was suggested that some were able to make this transition gradually, if at all. This tends to emphasize the fact that although they had developed considerable insight into their problems, reconstruction and reintegration of the personality was not always achieved. However, the over-all contribution of psychotherapy proved to be of substantial benefit in their academic contributions and personal lives as well.—NATHANIEL BERNSTEIN, M.D., Bureau of Child Guidance, Board of Education, New York, N. Y.

THE WIDENING WORLD OF CHILDHOOD: PATHS TOWARD MASTERY

By Lois Barclay Murphy and
collaborators

New York, Basic Books Inc., 1962, 399 pp.

This book reports a unique longitudinal development study of certain special ego functions of the normal young child. Unfortunately, the title does not do the book justice, although the subtitle "Paths Toward Mastery" is more apt. Using the concept "coping," the authors studied the ways young children master the countless inner and outer problems in new situations dur-

ing their early years and which result in the evolution of their egos, personality or character.

They state: "Coping devices involve choices in ways of using these resources, and also new structures and integrations developed by the individual organism to master its individual problems with the environment." "Coping" is distinguished as the process, while "mastery," "competence" and "adaptation" are the result; in the process, new responses become crystallized, the ego being the richer beyond reflex, habitual or other automatic actions.

The study sample covered 32 children from 2 or 3 years of age over a period of 12 years up to adolescence, and this first volume focuses on the preschool years. The children were from the middle-class white (Protestant or Catholic) majority in a middle-sized midwest American town (Topeka, Kan.). Their environment was particularly characterized by more freedom of movement than in a larger urban community, and conservative leanings, with repression of sex and much discipline to block early destructive impulses.

Striking themes are the natural great courage and enterprise of children, the remarkable number and extent of difficulties faced by the usual child, and the many variations of ego growth that are effected. The problem of presentation, as in most longitudinal studies, is the accumulation of data and how this can be organized and patterned in a meaningful way to give a usable theoretical framework. Dr. Murphy uses basic developmental concepts of psychoanalytic theory of drives and ego of Anna Freud, Hartmann and those of Gesell, Piaget, Erikson, and others.

The book is divided into four parts: I. the "New and the Strange," which considers how children encounter newness, difficulties

and challenges; II. "Crises," details how one child deals with an accidental amputation of a finger tip and how another overcomes sequelae of polio; III. "Aspects of Mastery," focuses on orientation, familiarization, autonomy, help, effort, flexibilities, drives, and coping strategies; and IV. "Coping and Development," its beginning, styles, activity, passivity, healthy narcissism and identity.

Written in a simple clear style with a minimum of technical vocabulary, the book still requires careful study for full appreciation. Among its few defects are the lack

of summaries at the end of each chapter and of some attempts for precise new theoretical generalizations to pull together the mass of valuable insightful data. Professionals working with normal and disturbed young children, as nursery school teachers, child psychologists, pediatricians and child psychiatrists, should find this book enlightening and valuable, as should laymen interested in mental hygiene and early human development. — ENRIQUE RIVERA-ROMERO, M.D., and ABRAM BLAU, M.D., The Mount Sinai Hospital, New York, N. Y.

Notes and Comments

TREATMENT FACILITIES

In line with recent federal mental health legislation, the Veterans Administration is operating centers in urban areas that offer a wide range of treatment and services to meet the needs of psychiatric patients.

One of these comprehensive mental health programs has been created at the West Side VA Hospital in Chicago.

Just about every practical tool developed in psychiatric research has been incorporated into some phase of the combined hospital-outpatient service program, according to hospital director John Foley Dee, M.D.

In the hospital itself is an intensive treatment inpatient area of 105 beds. In the adjacent outpatient service building there are supporting programs, some of them restricted by law to veterans whose mental illness results directly from military service.

There is also a mental hygiene clinic with both day and evening services available to veterans with service-connected disabilities. And there is a day treatment center to which veterans may come while bridging the gap between hospitalization and return to community life.

In addition, in each veteran's home town there is a combined psychiatric and pharmacy program available to service-connected veterans who cannot make the trip to the Chicago clinic. The VA pays the bills for this fee-basis treatment at home.

For the non-service-connected veteran a form of outpatient service known as "continued bed occupancy care" has been developed within the hospital. The veteran leaves the hospital but returns periodically for a period of treatment limited to one year for medication or psychotherapy.

An integral part of the program in both hospital and clinic is the social work serv-

ice which counsels and supervises the veteran once he leaves his hospital bed.

Both the hospital and outpatient service benefit from affiliations with the Illinois University Medical School and the Chicago Medical School. The schools provide a deans' committee to supervise treatment and assist in research. Many of the hospital's psychiatrists and psychologists hold teaching posts, while the schools' faculties, in turn, provide consultant services not only to the full-time staff but also to the residents in the psychiatric training program.

TRAINING

On July 1 the Family Study Center at the University of Minnesota began its post-doctoral training program in marriage counseling. The National Institute of Mental Health has provided training stipends of \$6,000 or \$7,000 per academic year.

The program is designed for psychotherapists and counselors who have a doctorate or M.S.W., with experience in psychiatry, counseling or clinical psychology, casework or pastoral counseling, and who wish to take additional special training in marriage counseling. Course work and practicum are tailored to the individual trainee's previous professional training and experience.

Further information may be obtained from Professor Gerhard Neubeck, Family Study Center, University of Minnesota, 1014 Social Science Tower, Minneapolis, Minn.

* * *

Graduate internships in rehabilitation counseling and predoctoral internships in counseling psychology are now available at the Devon, Pa., branch of the Devereux Schools, a group of residential treatment and rehabilitation centers located in sub-

urban Philadelphia. The program covers a full-time period of intensive training with emphasis on understanding problems of and work with mentally retarded and/or emotionally disturbed children, adolescents and young adults presenting problems of personal adjustment.

Preference will be given to applications from graduate students currently enrolled in, or graduated from: Vocational Rehabilitation Administration-supported rehabilitation counselor-training programs, American Psychiatric Association approved counseling or clinical psychology programs, or equivalent programs providing sufficient background for the advanced experience of a Devereux internship. Tax exempt stipends ranging from \$2,000 to \$3,400 are available; room and board is offered without charge to unmarried applicants, and an allowance of \$40 per month is provided to married interns.

Further information and training application blanks are available from Henry Platt, Ph.D., director of training, the Devereux Foundation Institute for Research and Training, Devon, Pa.

APPOINTMENTS AND ELECTIONS

Howard P. Rome, M.D., head of the psychiatric section of the Mayo Clinic, Rochester, Minn., was elected president-elect of the American Psychiatric Association at the Association's annual meeting held in Los Angeles May 4-8.

Daniel Blain, M.D., Philadelphia, took over as president for 1964-1965 at the close of the Los Angeles meeting. He succeeds Jack Ewalt, M.D., Boston. The newly-elected president-elect will automatically succeed Dr. Blain at the close of the APA's next annual meeting, to be held in New York City May 3-7, 1965.

Addison M. Duval, M.D., director of the division of mental health in Georgia's De-

partment of Public Health, and Aldwyn B. Stokes, M.D., chairman of the Department of Psychiatry at the University of Toronto, were elected APA vice-presidents. Harvey J. Tompkins, M.D., director of the Department of Psychiatry, St. Vincent's Hospital, New York City, was re-elected secretary. Dale C. Cameron, M.D., superintendent, St. Elizabeths Hospital, Washington, D. C., was elected treasurer of the Association.

Elected councilors for three-year terms were Stewart T. Ginsberg, M.D., commissioner of Mental Health for Indiana; Reginald Lourie, M.D., director of the psychiatric service, Children's Hospital, Washington, D. C.; and George Tarjan, M.D., director, Pacific State Hospital, Pomona, Calif.

AWARDS AND GRANTS

Bill Burrus, reporter for the *Dallas Times-Herald*, received the 1964 Albert Lasker Medical Journalism newspaper award for his front-page series on childhood mental illness in that city. The series, titled "Tomorrow's Damned," was written in February, 1963.

In his five-part series Mr. Burrus emphasized the absence in Dallas of psychiatric centers and of public understanding, especially in the schools, of the need for recognition and care of emotional disturbances in children. Partly as a result of the newspaper articles, action was taken by the Junior League, the state legislature, the PTA and other groups to remedy the situation through appropriations, educational steps and legislation.

NBC-TV reporter Paul Cunningham also received a Lasker award for a series on mental retardation, telecast on his network's "Today" show.

The Lasker awards were presented at a luncheon in New York City on May 13.

Two daily newspapers, the *Florida Times-Union* of Jacksonville, and the *Bridgeport, Conn., Post*, were named recipients of the 12th annual National Mental Health Bell Award presented by the National Association for Mental Health.

The Bell Award is made annually to an American daily newspaper in recognition of distinguished year-round editorial support of the attack on mental illness.

* * *

"The 91st Day," the dramatic film on mental illness produced by Smith Kline and French Laboratories in collaboration with the National Association for Mental Health, received a Blue Ribbon Award at the recent sixth annual American Film Festival.

The film was awarded first prize as the outstanding entry in the category "Mental Health Films for General Audiences." The festival is sponsored by the Educational Film Library Association.

"The 91st Day" was produced to stimulate public interest in improving community care and treatment of the mentally ill. It chronicles the mental breakdown of a teacher and his wife's struggle to get him the treatment he needs.

* * *

At its annual meeting in Los Angeles May 4-8 the American Psychiatric Association presented the following awards for outstanding accomplishment in various fields of psychiatry.

- The \$1500 Lester N. Hofheimer prize for research went to William C. Dement, M.D., Ph.D., associate professor of psychiatry at Sanford University School of Medicine, Palo Alto, Calif. Dr. Dement was awarded the prize for his work on the nature and function of sleep and dreaming, a line of research he has pursued since he was a medical student at the University of Chicago, 1951-1955.

- The APA's \$1000 Issac Ray Award for furthering understanding between psychiatry and the law was presented to Judge Justin Wise Polier of the New York State Family Court, New York City. As recipient, Judge Polier will deliver a series of lectures on psychiatry and the law at an American university to be announced.

Since her appointment as justice of the New York State Domestic Relations Court in 1935, Judge Polier has been a leading proponent of the view that adequate mental health services are indispensable to juvenile courts and their probation staffs. She has also been a pioneer in working out sound principles and practices in the area of adoption, and a civic leader in furthering a range of community mental health and social services.

- Edith B. Jackson, M.D., visiting professor of pediatrics and psychiatry at the University of Colorado School of Medicine, Denver, is the first recipient of the \$500 Agnes McGavin award for an outstanding contribution to the prevention of emotional disorders in children.

Dr. Jackson is best known for developing the concept and promoting acceptance by hospitals of the "rooming in" practice whereby newborn babies are kept in the same hospital room with their mothers. She has also worked extensively on the problem of the premature baby and his special susceptibility to emotional difficulties.

- The 1963 Mental Hospital Achievement award winners are: the Neuropsychiatric Institute of the University of Michigan Medical Center, Ann Arbor, in recognition of its outstanding achievement in the development of intensive treatment services for emotionally disturbed adolescents; the U.S. Veterans Administration Hospital, Northport, Long Island, N. Y., for fostering a self-management program for mental

patients; and Camarillo State Hospital, Camarillo, Calif., for developing an efficient new admission procedure and for developing a volunteer program to assist the relatives of patients during commitment hearings.

* * *

The Penn Foundation for Mental Health, Inc., Sellersville, Pa., has been awarded the first Earl D. Bond Award established by the Mental Health Association of Southeastern Pennsylvania. The award was presented to the Foundation "in recognition of the almost prophetic way it has fulfilled the vision of comprehensive community mental health centers as outlined by the late President John F. Kennedy."

* * *

The School of Applied Social Sciences at Western Reserve University, Cleveland, has received a grant of \$154,224,000 from the National Institute of Mental Health.

The purpose of the grant is to train social workers in the field of mental health. The grant will provide for a training director, who will be on the staff of the Cleveland Mental Health Association and on the faculty of the School. It also will supply stipends and tuition for four students.

* * *

The National Science Foundation has granted \$275,000 to Educational Testing Service, Princeton, N. J., for the construction of a \$1,100,000 behavioral research center and laboratory. Construction of the 100-room research center on the 350-acre ETS site in Princeton has already begun.

REHABILITATION

President Johnson has pledged that the federal government, as an employer, "intends to show the nation what can be done to make fuller use of the abilities of handi-

capped persons, including the mentally restored and the qualified mentally retarded."

In an official memorandum addressed to the heads of executive departments and agencies, the President said that utilizing the skills of these handicapped persons will mutually benefit "those persons, the agencies that employ them, and the public."

He urged the heads of federal agencies and their subordinates to "constantly examine the work to be done and apply imagination and ingenuity to re-engineering jobs; to retraining employees; to finding less demanding assignments for those who become ill or injured, when this is necessary to their continued employment; and to dealing with the handicapped on the basis of ability and fair play."

The Civil Service Commission will coordinate this federal employment effort and will report the results directly to the President.

REPORTS AND SURVEYS

"The Psychiatrist as a Consultant to the School," a report of the American Psychiatric Association's Committee on Preventive Psychiatry" was published recently by the APA. The report concludes that "the psychiatrist is a man equipped with tools who can be of prime service to the school . . . that in serving the school where much hinges around the changes and modifications of personality that occur with the passage of years, the psychiatrist is uniquely fitted as a physician to understand the manifold changes that occur in a child."

Copies of the report may be obtained from the Publications Office of the APA, 1700 18th St. N.W., Washington, D. C. Single copies are \$.50, with special rates for quantity orders.

The National Institute of Mental Health has issued its first report on the national psychiatric aide survey conducted last year in co-operation with the National Association for Mental Health.

The report, titled "Highlights from Survey of Psychiatric Aides," presents summary information on a number of characteristics of the psychiatric aide and his job setting in state and county mental hospitals in the United States. A final and more technical report will be printed later.

Copies of the "Highlights" report are available at \$.20 each from the Superintendent of Documents, Government Printing Office, Washington, D. C.

MEETINGS AND CONFERENCES

The First International Congress of Psychodrama will be held in Paris August 31-September 3, 1964, under the sponsorship of the French ministers of National Education, Labor and Social Security, Public Health and Population, and of the dean of the Faculty of Medicine, University of Paris.

Further details may be obtained from J. L. Moreno, M.D., P.O. Box 311, Beacon, N. Y.

* * *

The InterAmerican Society of Psychology will hold its Ninth Congress in Miami, Fla., December 16-21, 1964. The central theme of the conference will be "Psychology for Cultural Progress."

* * *

The 14th Annual Meeting and Mental Health Assembly of the National Association for Mental Health will be held at the Hilton Hotel in San Francisco, November 18-21, 1964.

Sessions of this year's Mental Health Assembly will deal with the program emphases of the NAMH as they relate to the

Association's division of function into the areas of science, service and social action. Implementation of President Kennedy's community mental health center program and the development of state mental health planning programs will be key reference points in the program sessions.

A post-conference mental health symposium, co-sponsored by the University of California Medical Center and the San Francisco Association for Mental Health, will be held November 21 and 22.

* * *

The role of organized labor in the development of comprehensive mental health services was outlined by leaders in the fields of mental health, medicine, insurance, labor and education at a recent meeting convened by the AFL-CIO Community Services Committee. The meeting was the outgrowth of a resolution on mental health adopted by the Fifth Constitutional Convention of the AFL-CIO, held in November, 1963.

In this resolution organized labor pledged its all-out support of the new community mental health services program. The statement reflects labor's desire not only to promote the development of better mental health services, particularly for low income groups, but also to assure that these services become part of the general program of health services negotiated through collective bargaining.

The suggestions made at the recent conference will serve as a basis for a detailed policy statement to be prepared by AFL-CIO staff for presentation to the organization's executive council.

PUBLIC INFORMATION

"Viewpoint on Mental Health," a series of programs on mental illness and mental health prepared by the New York City

Community Mental Health Board, is being aired on a number of the nation's educational television and radio stations. The series can be seen in New York City, in Memphis, Tenn., in Detroit, Mich., Tampa, Jacksonville and Tallahassee, Fla.; Austin and Houston, Tex.; Pittsburgh, Pa.; Athens, Ohio; Vermillion, S. D.; Phoenix, Ariz.; Portland and Corvallis, Ore.; Des Moines, Iowa; Hollywood and San Mateo, Calif.; Mobile, Ala.; Washington, D. C.; Chicago and Urbana, Ill.; throughout the states of Oklahoma and South Carolina, and in San Juan, Puerto Rico.

PUBLICATIONS

The "bold new approach" to problems of mental illness reflected in the passage of the Community Mental Health Centers Act of 1963 is described in the pamphlet "Community Mental Health Advances," issued by the U.S. Department of Health, Education and Welfare.

The pamphlet, prepared by the National Institute of Mental Health, gives details not only of the Community Mental Health Centers Act but also other federally-aided programs in the mental health field. Also included are sections on recent state legislation related to mental health, a calendar of events for 1964 and current reading.

Copies of "Community Mental Health Advances" may be obtained at \$.20 each from the Superintendent of Documents, Government Printing Office, Washington, D. C. Single copies are available free of charge from the Publications and Reports Section, NIMH, Bethesda, Md.

* * *

A booklet on the outstanding features and significance of the comprehensive community mental health center programs has also been prepared by the NIMH. The booklet, titled "The Comprehensive Com-

munity Mental Health Center: Concept and Challenge," outlines procedures for sponsoring and financing the centers.

* * *

COMEBACK, INC., has published several new guides on therapeutic recreation services for the chronically ill, the aged and the handicapped.

These include: "Suggestions for the Greater Enjoyment of the New York World's Fair: For the Aged and Disabled, Their Families and Friends," (\$.25); "Selected Readings in Psychiatry" and "Interdisciplinary Communication in Psychiatric Mental Health Programs," also \$.25 each; "Therapeutic Recreation Services for Narcotics Addicts: A Brief Description," free; and "Source Material: Therapeutic Recreation Services," free.

These materials may be obtained from COMEBACK, 16 West 46th St., New York, N. Y.

MENTAL HEALTH WEEK CEREMONY FEATURES TRIBUTE TO LATE PRESIDENT

Representatives of more than 100 professional, governmental and voluntary organizations joined the National Institute of Mental Health and the National Association for Mental Health in a tribute to President John F. Kennedy, launching Mental Health Week and Month, 1964.

The tribute ceremony was held at the World's Fair Grounds in Flushing, N. Y., on April 30.

The principal speakers included Robert H. Felix, M.D., director, NIMH; Frank E. Proctor, NAMH president; M. Ralph Kaufman, M.D., vice president, American Psychiatric Association; and Gerald Dorman, M.D., member of the board of trustees, American Medical Association. Messages of greeting were sent by President Lyndon

B. Johnson and Anthony Celebrezze, Secretary of Health, Education and Welfare.

DATES SET FOR COMMUNITY HEALTH WEEK

The second annual Community Health Week sponsored by the American Medical Association will be observed October 18-24, 1964. The purpose of the special week is to attract public attention to the medical and health facilities existing in all communities.

IN MEMORIAM

The death of Franz Alexander, M.D., in Los Angeles on March 8, 1964, was a deep loss to the medical profession: While he spent his life as a psychoanalyst, his contributions to psychosomatic medicine influenced every practitioner who has to deal with all those medical syndromes in which psychological factors play an important role.

His theories served to stimulate considerable controversy and, consequently, greater clarification of the etiology of these disorders. However, his greatest contributions were in the area of his greatest interest—psychoanalytic theory and treatment.

Dr. Alexander played a prominent role in making psychoanalysis a medical discipline and in helping it take root in the American culture. In 1946, in a research project in Chicago, he formulated the notion of the "corrective emotional experience" as the crucial element in therapy. He recommended that the analyst adopt an attitude directly opposite to that of the person who plays a crucial role in the patient's life. The results were most striking and were reported in the book *Psychoanalysis and Psychotherapy*. Dr. Alexander concluded that learning and experiencing, as

well as insight, were crucial to the cure of the neurosis. His notions have had a lasting effect on psychoanalytic treatment as it is practiced today.

Dr. Alexander also had a broad interest in social and political matters. His philosophical background served him well in several books where he explored the role of democracy in the present world.

He also played an important role in the organization of psychoanalysis in the United States and at the time of his death was president of The Academy of Psychoanalysis. He was past president of the American Psychoanalytic Association and clinical professor of psychiatry at the University of Southern California. His research activities were manifold, and he was the author of innumerable books and articles in this field.

Franz Alexander will hold a high place in the ultimate history of the behavioral sciences. His flexibility, erudition and support for younger colleagues who dared experiment in the sciences of human behavior will earn him undying respect. Because of his own activity he has left behind a heritage of curious, dissident and idiosyncratic workers who will make the future contributions in the growing area of human behavior.—LEON SALZMAN, M.D., President, The Academy of Psychoanalysis.

ARTICLES SCHEDULED FOR PUBLICATION IN FUTURE ISSUES OF MENTAL HYGIENE

- "The Concept of a Community Mental Health Clinic: Fact or Fiction?" by Michael J. Pacella.
- "Contributions of a Speech Pathologist to the Psychiatric Examination of Children" by Clyde L. Rousey and Povl W. Toussieng.
- "A History of Challenges in Child Psychiatry Training" by I. N. Berlin.
- "Alcoholics Anonymous Principles and the Treatment of Emotional Illness" by Felix Cohen.

- "Therapeutic Approaches in a Psychiatric Day Treatment Center" by Julian Meltzoff and A. A. Richman.
- "Reactions of Children During Hospital Admission: Three Diaries" by Joseph Mayer.
- "Functions of the State Mental Hospital as a Social Institution" by Robert M. Edwalds.
- "Foster Home Variables and Adult Outcomes" by H. B. M. Murphy.
- "Pragmatic Psychiatry and Traveling Community Mental Health Clinics" by Lindbergh S. Sata.
- "A Perspective on the Function of the Psychiatric Halfway House" by Geoffrey A. Sharp.
- "Psychiatric Role of Physical Medicine and Rehabilitation in the Third Revolution" by John Eisele Davis, Sr. and John Eisele Davis, Jr.
- "Basic Issues and Problems in Attendant Training" by M. K. Distefano, Jr. and Margaret W. Pryer.
- "An Evaluation of the Effectiveness of a Mental Hygiene Video Presentation on Adjustment" by Robert M. Blume, Sheldon Blackman and Jonah P. Hymes.
- "A Note on Tolor's 'The Personality Need Structure of Psychiatric Attendants,'" by M. Powell Lawton.
- "Is There Inner Strength for Mental Troubles?" by Ordway Tead.
- "The Public Image of the Sex Offender" by Gerhard J. Falk.
- "Discovering and Meeting the Mental Health Needs of Emotionally Disturbed Elementary School Children, with Emphasis on Children Whose Parents Are Inadequate" by Sol Gordon, Morris Berkowitz and Charles Cacace.
- "Family Organization on a Modern State Hospital Ward" by H. Peter Laqueur and Harry A. LaBurt.
- "Two Remarkable Achievements of Social Therapy: The French Psychiatric Hospitals of Saint-Alban and Lannemezan" by Paul Rajotte and Herman C. B. Denber.
- "Attitudes and Opinions of Clergymen about Mental Health and the Causes of Mental Illness" by Richard F. Larson.
- "Implications of Process-Reactive Schizophrenia for Rehabilitation" by R. E. Kantor.
- "Effect of Physician Training in Mental Health Principles on Mothers' Appraisal of Child Health Conference" by Marvin Belkins, Edward S. Suchman, Daniel Rosenblatt and Harold Jacobziner.
- "The Stigma of Mental Illness Can Be Erased" by Sister Loretta Maria.
- "A Study of the Use of Mental Health Media by the Lay Public" by Alexander C. Rosen and Frank F. Tallman.
- "The Integration of Community Psychiatry Training in a Traditional Psychiatric Residency" by Robert S. Daniels and Philip M. Margolis.
- "Specialization and Under-Utilization" by Mortimer Schiffer.
- "The Impact of Psychiatric Hospital Experience on the Community Adjustment of Patients" by David G. Berger, Charles E. Rice, Lee G. Sewall and Paul V. Lemkau.
- "Constructive Use of Psychiatric Consultation in a Rehabilitation Program" by Meyer S. Gunther, Clement Blakeslee and Ralph W. Susman.
- "The Role of the Psychiatrist in the Peace Corps" by Philip M. Margolis.
- "Mental Health Factors in an Indian Boarding School" by Thaddeus P. Krush and John Bjork.
- "Metastasis: A Social Psychological Concept Concerning Mental Health and Illness" by Martin Bloom.
- "Interviewing Techniques for Social Work Student Training" by George C. Alphine, Robert Chester, Nathan H. Kaufman, John K. Matsumuro and Murray K. Cunningham.
- "The Social Psychology of Prejudice" by Nathan W. Ackerman.
- "A Study of Children's Attitudes Toward the Cuban Crisis" by Bernice T. Eiduson.
- "A Skeptic's View of the Mental Illness Game" or "An Old State Hospital Hand's Jaundiced Look at Progress" by Walter B. Simon.
- "Personality Correlates of the Orientation of Mental Hospital Attendants" by Neil F. Thomas, Robert L. Houk and Herbert S. Ripley.
- "Studies of Medical Student Attitudes Toward Mental Illness" by Leonard F. Salzman and Robert H. Goldstein.
- "Expanding Comprehensiveness of Psychiatric Rehabilitation" by Laurence C. Hartlage.
- "Pupil Perception of Parental Attitudes Toward School" by Margaret Barron Luszki and Richard Schmuck.
- "Combating Post-Hospital Bends: Patterns of Success and Failure in a Psychiatric Halfway House" by Patricia Gumrukcu and Elaine Mikels.
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INTRODUCTION

When native-born and foreign-born whites are compared with respect to relative frequencies of first admissions to hospitals for mental disease—due regard being given to differences in sex and age proportions—it appears that there are few significant differences in such rates.

However, the foreign-born differ among themselves. Irish-born, for example, have rates well above the averages for either native-born or total foreign-born. Those of Italian birth, on the contrary, have rates below the average.

The native-born are not a homogeneous population. They differ among themselves in many ways, one of the most important being with respect to the nativity of their parents. Thus, natives may belong to stocks representing one or more generations of native-born ancestors. Or they may belong to a generation whose parents were both foreign-born.

On the other hand, the parental generation may be mixed, consisting of one native and one foreign-born parent. Just as the incidence of mental disease varies between native and foreign-born, so we must inquire into the possible variations within the native-born group. Furthermore, natives of foreign and mixed parentage may be considered part of the foreign stock, and may therefore be classified according to the country of origin of the parents. Just as we found significant differences in incidence between the several populations of foreign birth, so there may be differences between native-born whose parents are of

Dr. Malzberg is principal research scientist, Research Foundation for Mental Hygiene, Inc., Albany, N. Y. This investigation was supported by a research grant from the National Institute of Mental Health (Grant M1140C4).

This is the last of a series of eight studies describing the frequency of mental disease among ethnic and national groups in the United States.

different foreign national and ethnic origins.

Furthermore, it is important to compare the two generations of foreign stock; namely, the foreign-born of specific foreign birth, and the first generation of native-born of corresponding parental origin.

In 1920, native whites totaled 7,385,915 in New York State; of these, 49.7 per cent were of native parentage, 11.8 per cent were of mixed parentage, and 38.5 per cent were of foreign parentage.¹ By 1950, the number of foreign-born had declined significantly because of the restriction of immigration since 1920. As a result, there was a change in the ratio of native to foreign-born, which, in turn, affected the ratios according to parentage.

Thus, in 1920, natives of native parentage represented 49.7 per cent of the total native-born,² but by 1950, the percentage had grown to 62.³ Natives of foreign parentage declined from 38.5 per cent of the total native-born population in 1920⁴ to 26.6 per cent in 1950.⁵

Similar changes occurred among patients with respect to nativity and parentage. Thus, in 1920, native first admissions of

native parentage constituted 28.3 per cent of total first admissions to the New York civil state hospitals, but they represented 39.6 per cent in 1950.⁶ Those of foreign parentage, on the other hand, decreased from 56.8 per cent of the total in 1920 to 46.9 per cent in 1950. Those of mixed parentage decreased slightly from 13.7 to 12.2 per cent.

Data for 1910 showed lower rates of admissions to hospitals for mental disease in the United States, per 100,000 population, among native whites of native parentage than among native whites of foreign or mixed parentage. The rates were 56.3 and 62.3, respectively.⁷ In the middle atlantic division (which includes New York, New Jersey and Pennsylvania) the corresponding rates were 59.1 and 65.9 respectively.

These were crude rates, however, and by themselves were inconclusive. Similar uncertainty must be attached to data for the United States in 1923, which showed an annual rate of first admissions of 46.6 per 100,000 for native whites of native parentage, 52.2 for native whites of foreign parentage, and 38.7 for native whites of mixed parentage.⁸

We shall proceed to a more systematic analysis by considering rates of first admissions according to nativity and parentage among native white first admissions to all public and private hospitals for mental disease in New York State from October 1, 1948, to September 30, 1951, inclusive.

There were 35,317 native white first admissions during this period, of whom 16,268 were of native parentage, 5,932 of mixed parentage, and 13,117 of foreign parentage. The mixed category included those with one parent native-born and the other foreign-born. It also included those with one parent foreign-born, the nativity of the other parent being unascertained.

¹ *Fourteenth Census of the United States, Vol. II. Population* (Washington, D. C.: Government Printing Office, 1920), p. 913.

² *Ibid.*

³ *United States Census of Population, 1950. Nativity and Parentage* (Washington, D. C.: Government Printing Office, 1954). Special Report P-E No. 3A, p. 35.

⁴ See footnote 1.

⁵ See footnote 3.

⁶ From the annual reports of the New York State Department of Mental Hygiene.

⁷ *Insane and Feeble-minded in Institutions, 1910* (Washington, D. C.: Government Printing Office, 1914), p. 39.

⁸ *Patients in Hospitals for Mental Disease, 1923* (Washington, D. C.: Government Printing Office, 1926), p. 21.

TABLE 1

Native white first admissions to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and mental disorders

<i>Mental disorders</i>	<i>Of native parentage</i>			<i>Of mixed parentage</i>			<i>Of foreign parentage</i>		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
General paresis	191	1.2	0.9	75	1.3	1.9	122	0.9	1.4
Alcoholic	945	5.8	4.4	318	5.4	8.2	713	5.4	7.9
With cerebral arteriosclerosis	2,218	13.6	10.5	1,043	17.6	26.8	2,007	15.3	22.2
Senile	1,476	9.1	7.0	639	10.8	16.4	1,557	11.9	17.2
Involutional	1,142	7.0	5.4	464	7.8	11.9	1,074	8.2	11.9
Manic-depressive	754	4.6	3.6	277	4.7	7.1	731	5.6	8.1
Dementia praecox	5,051	31.0	24.0	1,881	31.7	48.4	4,739	36.1	52.4
Other	4,491	27.6	21.3	1,235	20.8	31.8	2,174	16.6	24.1
Total	16,268	100.0	77.2	5,932	100.0	152.7	13,117	100.0	145.2

This is in accordance with the system of classification employed by the Bureau of the Census.

Of the 16,268 native white first admissions of native parentage, 5,051, or 31.0 per cent, were diagnosed as dementia praecox. The second largest group was psychoses with cerebral arteriosclerosis, which included 2,218 first admissions, or 13.6 per cent of the total. The senile psychoses included 1,476, or 9.1 per cent. The involutional psychoses followed with 1,142, or 7.0 per cent. The alcoholic psychoses included 945, or 5.8 per cent.

Dementia praecox was also the leading category among native white first admissions of mixed parentage, including 1,881 of the total of 5,932, or 31.7 per cent, equivalent to that of the population of native parentage. Psychoses with cerebral arteriosclerosis included 1,043 cases, or 17.6 per cent of the total. Senile psychoses included 639, or 10.8 per cent.

Among native whites of foreign parentage, dementia praecox led with 4,739 first admissions, or 36.1 per cent of the total. Psychoses with cerebral arteriosclerosis followed with 2,007 cases, or 15.3 per cent, and senile psychoses included 1,557, or 11.9 per cent.

The variation between the several nativity classes with respect to the distribution of the groups of mental disorders was related in large part to the age structures of the populations. Thus, natives of native parentage had a median age of 24.4 years. Natives of mixed parentage had a median age of 26.1 years. But natives of foreign parentage had a median age of 35.9 years. The relatively high percentage of dementia praecox among the latter was due to the fact that 64.4 per cent were aged 15 to 44, compared with 42.0 per cent of natives of native parentage, and 48.4 per cent of natives of native parentage.

Those of native parentage had an aver-

age annual rate of 77.2 per 100,000 population. Dementia praecox led with a rate of 24.0, followed by psychoses with cerebral arteriosclerosis with a rate of 10.5, and senile psychoses with a rate of 7.0.

Those of mixed parentage had an average annual rate of 152.7 per 100,000. The rate for dementia praecox was 48.4. The rates for psychoses associated with advanced age were also high—26.8 for psychoses with cerebral arteriosclerosis and 16.4 for senile psychoses.

The greatest contrast occurred with respect to the category of foreign parentage. Although the total rate—145.2 per 100,000—did not differ markedly from that for natives of mixed parentage, the rate for dementia praecox was 52.4, compared with

24.0 for those of native parentage, and 31.8 for those of mixed parentage.

As indicated previously, such comparisons are affected by the varying age structures of the several nativity groups. Direct comparisons of age-specific rates are therefore of greater significance.

Table 2 shows such rates for natives of native parentage. The rates increased to a maximum of 497.1 per 100,000 at ages 75 and over. In general, males had higher rates than females, except for the involutional period between ages 30 and 44. Beyond age 45, rates for males exceeded those for females in a somewhat increasing ratio.

Among natives of mixed parentage, the rates rose to a maximum of 1,257.7 at ages

TABLE 2

Native white first admissions to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	344	2.1	4.6	100	1.7	9.0	64	0.4	56.8
15-19	1,035	6.4	66.3	357	6.0	93.9	480	3.7	92.2
20-24	1,620	10.0	99.4	602	10.1	156.6	1,083	8.3	133.8
25-29	1,699	10.4	103.7	537	9.1	156.3	1,382	10.5	132.3
30-34	1,419	8.7	96.1	468	7.9	158.4	1,444	11.0	116.4
35-39	1,410	8.7	106.4	492	8.3	195.1	1,297	9.9	106.5
40-44	1,284	7.9	104.4	439	7.4	190.7	1,166	8.9	118.6
45-49	1,141	7.0	107.1	425	7.2	211.8	869	6.6	125.9
50-54	1,013	6.2	105.4	363	6.1	195.7	865	6.6	149.2
55-59	903	5.6	117.2	332	5.6	213.7	721	5.4	171.2
60-64	834	5.1	131.3	336	5.7	270.7	593	4.5	203.2
65-69	760	4.7	148.2	340	5.7	343.0	595	4.5	282.3
70-74	827	5.1	240.4	358	6.0	537.5	710	5.4	467.1
75 and over	1,974	12.1	497.1	782	13.2	1,257.7	1,838	14.0	958.6
Unascertained	5	*	..	1	*	..	10	0.1	..
Total	16,268	100.0	77.2	5,932	100.0	152.7	13,117	100.0	145.2

* Less than 0.05.

TABLE 3

*Average annual standardized * rates of first admissions to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

<i>New York State</i>						
	Of native parentage (a)	Of mixed parentage (b)	Of foreign parentage (c)	c — a	c — b	b — a
Males	126.9±1.64	238.0±5.00	190.8±2.55	1.50	0.80	1.88
Females	116.3±1.49	229.0±4.59	160.4±2.24	1.38	0.70	1.97
Total	123.2±1.11	233.1±3.42	178.4±1.71	1.44	0.74	1.93
<i>New York City</i>						
Males	126.3±2.73	230.4±6.81	181.6±3.08	1.44	0.79	1.82
Females	123.1±2.54	233.8±6.44	171.3±2.86	1.39	0.73	1.90
Total	125.9±1.87	237.2±4.73	180.1±2.12	1.43	0.76	1.88

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

75 and over. As with native parentage, males had higher rates than females, except during the involutional period.

Rates increased among natives of foreign parentage to a maximum of 958.6 at ages 75 and over. Rates for females exceeded those for males between ages 30 and 49, but rates for males were in excess in generally increasing ratios at older ages.

Direct comparisons of age-specific rates are given in Table 2. The lowest rates occurred among those of native parentage. Among males, rates for those of foreign parentage exceeded those of native parentage in decreasing ratios through ages 30 to 34, and in increasing ratios at higher ages. Those of mixed parentage had the highest rates. They exceeded corresponding rates for those of native parentage in exceptionally high ratios at older ages. The most striking comparison is between those of mixed parentage and those of foreign parentage. At every age beyond

20 those of foreign parentage had significantly lower rates.

Similar comparisons occurred among females. The highest age-specific rates were for those of mixed parentage; the lowest were for those of native parentage. In between were the rates for those of foreign parentage. Rates for the latter were higher than those for natives of native parentage, but by moderate amounts up to age 60. On the other hand, their rates were significantly lower than those for natives of mixed parentage.

The differences in age-specific rates are summarized in Table 3 by means of standardization. The several nativity aggregates were compared on the basis of a similar age and sex structure, the standard population being that of the white population of New York State, aged 15 years and over on April 1, 1950.

We now find a rate of 123.2 per 100,000 among natives of native parentage, com-

pared with 178.4 among those of foreign parentage. The latter was in excess by 44 per cent, compared with an excess of 88 per cent based upon crude rates. The highest rate, 238.1, occurred among natives of mixed parentage. This exceeded the rate for natives of native parentage by 93 per cent, and exceeded that for natives of foreign parentage by 33 per cent.

Rates of first admissions are further influenced by the urban-rural ratios among the several populations. Those of foreign and mixed parentage have larger proportions in urban areas than natives of native parentage, and their rates tend to be somewhat higher for this reason. It is therefore desirable to standardize further with respect to this environmental difference. However, this cannot be done directly, because the definitions of urban-rural for first admissions in 1950 were not the same as those adopted by the Bureau of the Census for the general population in that year. An approximate standardization according to gross environmental differences may be made by limiting the comparisons to New York City.

The distribution of the general native white population of New York City according to age and parentage was not given in 1950, but the proportions were assumed to be the same as for the metropolitan area consisting of New York and northeastern New Jersey. Since New York City includes the great majority of the population of this area, the estimates may be accepted as reasonable.

Standardized rates of first admissions from New York City did not differ significantly, on the whole, from those for New York State. Natives of mixed parentage had a rate of 237.2 per 100,000, which exceeded that for natives of native parentage by 88 per cent, and exceeded that for

natives of foreign parentage by 32 per cent. The rate for the latter, in turn, exceeded that for natives of native parentage by 43 per cent.

Although natives of foreign parentage undoubtedly have a higher rate of first admissions than natives of native parentage, the difference is exaggerated by the system of classification employed by the Bureau of the Census. Thus, native whites, one or both of whose parents were unascertained with respect to nativity, were considered as belonging to the category of native parentage. This raised the population base, and caused a corresponding decrease in the category of natives of foreign parentage. This necessarily lowered the rate for those of native parentage and raised that for natives of foreign parentage.

Furthermore, it is certain that classification of first admissions with respect to parentage is more accurate than that for the general population, including fewer unascertained cases. It is a reasonable inference, therefore, that the rate for natives of foreign parentage is lower and that for natives of native parentage is higher in unknown proportions than that shown above.

Natives of foreign parentage consist of many populations, varying in the incidence of first admissions. In classifying according to nativity of parents, we followed the principle of the Bureau of the Census in assigning nativity in case of mixed foreign parentage to the nativity of the father.

Natives of native parentage had an average annual standardized rate in New York State of 123.2 per 100,000. But natives of Italian-born parentage had a rate of 114.6. The highest rate was 220.2 for natives of Irish-born parentage. There were no essential differences when comparisons were limited to New York City.

General Paresis

There were 191 first admissions with general paresis among native whites of native parentage during 1949-1951, or an average annual rate of 0.9 per 100,000. There were 75 such admissions among native whites of mixed parentage, or a rate of 1.9. The 122 first admissions among those of foreign parentage gave a rate of 1.4.

The rates rose to a maximum of 3.8 per 100,000 at ages 45 to 49 among those of native parentage, and to 5.9 among those of mixed parentage at ages 50 to 54. The maximum rate among those of foreign parentage was 6.2 at ages 55 to 59. In each nativity group, the rates for males were in significant excess over those for females.

Table 4 compares rates of first admissions at corresponding ages. The highest rates occurred among natives of mixed parentage. These exceeded the corresponding rates for those of native parentage in ratios that increased with advancing age. Natives of foreign parentage had lower rates than those of native parentage at younger ages, but significantly higher rates at older ages. The former had significantly lower rates than natives of mixed parentage.

Part of the differences in crude rates was due to the fact that natives of native parentage had a larger proportion at ages within the range of general paresis. The rates were therefore standardized with respect to age and sex. (See Table 5.)

TABLE 4

Native white first admissions with general paresis to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	..	..	..	2	2.7	0.2	..	..	..
15-19	4	2.1	0.3	3	4.0	0.8	..	..	..
20-24	2	1.0	0.1	..	..	..	..	..	..
25-29	4	2.1	0.2	1	1.3	0.3	..	..	..
30-34	5	2.6	0.3	4	5.3	1.4	3	2.4	0.2
35-39	22	11.5	1.7	8	10.7	3.2	8	6.6	0.7
40-44	35	18.3	2.8	12	16.0	5.2	18	14.8	1.8
45-49	40	21.0	3.8	11	14.7	5.4	19	15.6	2.8
50-54	31	16.2	3.2	11	14.7	5.9	18	14.8	3.1
55-59	19	10.0	2.4	7	9.3	4.5	26	21.3	6.2
60-64	15	7.9	2.4	8	10.7	6.4	14	11.4	4.8
65-69	6	3.1	1.2	5	6.7	5.0	7	5.7	3.3
70-74	6	3.1	1.7	2	2.7	3.0	5	4.1	3.3
75 and over	2	1.0	0.5	1	1.3	1.6	4	3.3	2.1
Total	191	100.0	0.9	75	100.0	1.9	122	100.0	1.4

TABLE 5

*Average annual standardized * rates of first admissions with general paresis to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

<i>New York State</i>						
	Of native parentage (a)	Of mixed parentage (b)	Of foreign parentage (c)	c — a	c — b	b — a
Males	2.2±0.22	4.4±0.68	2.8±0.31	1.27	0.64	2.00
Females	1.1±0.14	2.2±0.45	1.1±0.19	1.00	0.50	2.00
Total	1.6±0.13	3.3±0.40	1.9±0.18	1.19	0.58	2.06
<i>New York City</i>						
Males	2.4±0.37	4.7±0.97	2.7±0.38	1.13	0.57	1.96
Females	1.2±0.25	2.4±0.67	1.1±0.22	0.92	0.46	2.00
Total	1.7±0.22	3.5±0.58	1.8±0.21	1.06	0.51	2.06

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

The standardized rates were 1.6 for natives of native parentage and 1.9 for natives of foreign parentage, the latter being in excess by 19 per cent. The excess had amounted to 56 per cent on the basis of crude rates, showing the distortion that may be created by an unfavorable age distribution. The highest rate—3.3—occurred among natives of mixed parentage.

Because of the greater incidence of syphilis in urban areas, the rates were standardized for New York City to approximate differences due to this factor. The revised rates were 1.7 per 100,000 for natives of native parentage, and 1.8 for natives of foreign parentage, a difference of only 6 per cent. This is not a statistically significant difference; in fact, the rate was lower for females of foreign parentage. The rate remained significantly higher for natives of mixed parentage.

The incidence of general paresis differs among important national and ethnic

groups. The average standardized rate for all natives of native parentage was 1.6 per 100,000, but this was exceeded by natives of Italian-born parentage, who had a rate of 3.9. Those of Irish-born and Polish-born parentage also had rates above the average. Because of limited data, it was impossible to standardize rates for several populations, but it is known from other sources that the incidence of general paresis is low among those of Russian origin, who consist largely of Jews.

Alcoholic Psychoses

Of the three categories of native whites, those of native parentage had the lowest average annual rate of first admissions with alcoholic psychoses during 1949-1951. Their rate of 4.4 per 100,000 compares with a rate of 7.9 for natives of foreign parentage. The highest rate, 8.2, occurred among natives of mixed parentage.

In general, rates of first admissions with alcoholic psychoses rose to maxima in middle life. However, the maximum was reached at a younger age by those of native parentage. There was also a sex difference in this respect, females having their maximum rate about 20 years younger than males among those of mixed and foreign parentage. Males had higher rates than females at corresponding ages. Below age 45, the sex ratio was greater among natives of native parentage.

At subsequent ages, the ratio was lowest among those of native parentage. There is a suggestion that at the older ages there is a greater similarity in drinking habits between the sexes among natives of native parentage.

The crude rate of native males of foreign parentage exceeded that of natives of na-

tive parentage by 82 per cent. However, there was a marked dichotomy with respect to age. Below age 50 natives of foreign parentage had lower rates. Beyond age 50 they were in excess in an increasing ratio. Below age 60, natives of foreign parentage had significantly lower rates than those of mixed parentage. The latter, in turn, had higher rates than natives of native parentage. Comparisons of age-specific rates among females agree generally with those for males.

Table 7 gives standardized rates of first admissions with alcoholic psychoses among the three parental groups. These were 8.4 per 100,000 for those of native parentage and 11.0 for those of foreign parentage. The latter was in excess by 31 per cent, compared with an excess of 82 per cent on the basis of crude rates. Natives of

TABLE 6

Native white first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	..	..	..	..	..	..	..	..	..
15-19	2	0.2	0.1	1	0.3	0.3	1	0.1	0.2
20-24	10	1.1	0.6	2	0.6	0.5	1	0.1	0.1
25-29	49	5.2	3.0	9	2.8	2.6	10	1.4	1.0
30-34	65	6.9	4.4	22	6.9	7.4	52	7.3	4.2
35-39	135	14.3	10.2	42	13.2	16.7	73	10.2	6.0
40-44	176	18.6	14.3	54	17.0	23.4	135	18.9	13.7
45-49	182	19.3	17.1	66	20.8	32.9	110	15.4	15.9
50-54	129	13.7	13.4	37	11.6	20.0	119	16.7	20.5
55-59	101	10.7	13.1	44	13.8	28.3	101	14.2	24.0
60-64	56	5.9	8.8	27	8.5	21.7	64	9.0	21.9
65-69	31	3.3	6.0	12	3.8	12.1	33	4.6	15.7
70-74	8	0.8	2.3	1	0.3	1.5	10	1.4	6.6
75 and over	1	0.1	0.3	1	0.3	1.6	4	0.6	2.1
Total	945	100.0	4.4	318	100.0	8.2	713	100.0	7.9

TABLE 7

*Average annual standardized * rates of first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

<i>New York State</i>						
	Of native parentage (a)	Of mixed parentage (b)	Of foreign parentage (c)	c — a	c — b	b — a
Males	13.9±0.58	25.9±1.79	18.7±0.83	1.34	0.72	1.86
Females	3.5±0.28	7.3±0.88	3.9±0.36	1.11	0.53	2.09
Total	8.4±0.31	16.2±0.90	11.0±0.44	1.31	0.68	1.93
<i>New York City</i>						
Males	15.1±1.01	25.4±2.45	17.3±0.98	1.14	0.68	1.68
Females	5.1±0.55	7.8±1.27	4.4±0.47	0.86	0.56	1.53
Total	9.9±0.56	16.2±1.34	10.6±0.53	1.07	0.65	1.64

* White population of New York State, aged 20 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

mixed parentage had a higher rate than either of the other two groups.

The rates were also standardized for New York City to provide a partial compensation for differences due to degree of urbanization. The importance of this adjustment is seen in the fact that the rate for natives of foreign parentage in New York City exceeded that for natives of native parentage by only 7 per cent, which is not statistically significant. The rate remained high, however, for natives of mixed parentage.

When natives of foreign parentage are classified according to specific nativity of parents, important contrasts develop. Thus, natives of Italian-born parentage had a standardized rate of 2.2, compared with 8.4 for those of native parentage. Those of Russian-born parentage had a rate of 2.1. This verifies the well-known fact of a very low rate of alcoholic psychoses among Jews, since the vast majority of

natives of Russian-born parentage living in New York State are Jews.

The highest rate, 21.7, occurred among those of Irish-born parentage. Data for New York City showed a similar spread between a minimum of 1.6 for those of Italian-born parentage and a maximum of 26.6 for those of Irish-born parentage. The rate for those of Polish-born parentage was reduced to 2.7, well below the average. This is also proof of the low rate of alcoholic psychoses among Jews, who predominate among those of Polish-born parentage living in New York City.

Psychoses with Cerebral Arteriosclerosis

The percentage at advanced age (for example, 65 and over) varied insignificantly among the three populations of differing parental origin. Nevertheless, the average annual rates of first admissions with psychoses with cerebral arteriosclerosis

varied from a minimum of 10.5 per 100,000 among natives of native parentage to 26.8 among those of mixed parentage. Natives of foreign parentage had a rate of 22.2. Generally, males had higher rates than females at corresponding ages, but there is variation in this respect among natives of mixed parentage.

At corresponding ages, natives of mixed and foreign parentage had higher rates than natives of native parentage. The excess was more marked among those of mixed parentage. Age-specific rates were lower among natives of foreign parentage than among those of mixed parentage, the difference being more marked among females.

Rates adjusted for differences in age and sex proportions are given in Table 9. On the basis of crude rates, the rate for natives of foreign parentage exceeded

that for natives of native parentage in the ratio of 2.11 to 1. The standardized rates were in the ratio of 1.97 to 1, indicating a significant difference. The rate for those of foreign parental origin was only 76 per cent of that for natives of mixed parentage. The spread between rates for those of native parentage and the other groups was reduced when comparisons were limited to New York City, but the differences remained highly significant.

The average standardized rate for natives of native parentage was 47.6. Natives of Italian-born parentage had a rate of 45.2; but other groups of natives of foreign parental origin had higher rates. Natives of Swedish-born parentage had a rate of 102.0. Those of Russian parental origin had a rate of 94.3. The rate was also high among those of Irish-born parentage.

TABLE 8

Native white first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 40	..	..	..	..	..	..	..	..	..
40-44	4	0.2	0.3	5	0.4	2.2	3	0.1	0.3
45-49	9	0.4	0.8	3	0.3	1.5	5	0.2	0.7
50-54	58	2.6	6.0	19	1.8	10.2	43	2.1	7.4
55-59	149	6.7	19.3	56	5.4	36.0	118	5.9	28.0
60-64	332	15.0	52.3	153	14.7	123.2	236	11.8	80.9
65-69	432	19.4	84.3	178	17.1	179.6	372	18.5	176.5
70-74	362	16.3	105.3	289	27.7	433.9	417	20.8	274.4
75 and over	871	39.3	219.4	340	32.6	546.8	811	40.4	423.0
Unascertained	1	*	..	..	..	..	2	0.1	..
Total	2,218	100.0	10.5	1,043	100.0	26.8	2,007	100.0	22.2

* Less than 0.05.

TABLE 9

*Average annual standardized * rates of first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

<i>New York State</i>						
	Of native parentage (a)	Of mixed parentage (b)	Of foreign parentage (c)	c — a	c — b	b — a
Males	55.7±1.86	120.8±6.46	103.9±3.46	1.87	0.86	2.17
Females	36.2±1.41	112.3±5.54	73.1±2.71	2.02	0.65	3.10
Total	47.6±1.18	123.3±4.34	93.7±2.24	1.97	0.76	2.59
<i>New York City</i>						
Males	55.7±3.29	126.4±9.68	97.2±4.23	1.74	0.77	2.27
Females	40.7±2.60	98.0±7.69	72.4±1.09	1.78	0.74	2.41
Total	49.7±2.11	117.2±6.24	88.8±2.77	1.79	0.76	2.36

* White population of New York State, aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

Senile Psychoses

There were 1,476 first admissions with senile psychoses among natives of native parentage during 1949-1951, or an average annual rate of 7.0 per 100,000. Crude rates for those of foreign or mixed parentage were considerably higher, being 17.2 and 16.4, respectively. The rate for females was in marked excess of those for males at corresponding ages.

Table 10 compares age-specific rates of first admissions among the native-born according to parental origin. Those of foreign and mixed parentage both had higher rates than natives of native parentage at all ages. Native males of foreign parentage had lower age-specific rates than those of mixed parentage, but this order of comparison did not prevail generally among females, possibly because of random variations.

On the basis of crude rates, the rate for

natives of foreign parentage exceeded that for native parentage in the ratio of 2.46 to 1. On the basis of standardized rates, the ratio was reduced slightly to 2.23 to 1; indicating a significantly higher rate for those of foreign parentage. Those of mixed parentage had a rate which exceeded that for foreign parentage in the ratio of 1.15 to 1, and exceeded the rate for native parentage in the ratio of 2.58 to 1. Rates for those of foreign parentage were also in excess in New York City.

All native whites of native parentage had an average annual standardized rate of 30.4 per 100,000 in New York State. But natives of Polish-born parentage had a rate of 27.6. The rate for natives of Russian-born parentage could not be standardized because of limited data, but it is known from previous studies that the rate is low for Jews, who constitute the large majority of this population. Those of Irish-born parentage had a rate of 62.9,

TABLE 10

Native white first admissions with senile psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 50	..	..	..	..	..	..	..	..	..
50-54	1	0.1	0.1	..	..	..	3	0.2	0.5
55-59	2	0.1	0.3	2	0.3	1.3	5	0.3	1.2
60-64	42	2.8	6.6	17	2.7	13.7	35	2.2	12.0
65-69	116	7.9	22.6	62	9.7	62.5	89	5.7	42.2
70-74	267	18.1	77.6	120	18.8	180.2	282	18.1	185.5
75 and over	1,046	70.9	263.4	437	68.4	702.9	1,139	73.1	594.0
Unascertained	2	0.1	..	1	0.2	..	4	0.3	..
Total	1,476	100.0	7.0	639	100.0	16.4	1,557	100.0	17.2

TABLE 11

*Average annual standardized * rates of first admissions with senile psychoses to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

	New York State					
	Of native parentage	Of mixed parentage	Of foreign parentage	c	c	b
	(a)	(b)	(c)	a	b	a
Males	23.7±1.21	62.5±4.64	56.6±2.56	2.39	0.91	2.64
Females	30.2±1.29	76.4±4.57	64.8±2.55	2.14	0.84	2.53
Total	30.4±0.94	78.3±3.46	67.9±1.91	2.23	0.87	2.58
	New York City					
	Of native parentage	Of mixed parentage	Of foreign parentage	c	c	b
	(a)	(b)	(c)	a	b	a
Males	33.2±2.54	68.5±7.14	41.8±2.77	1.26	0.61	2.06
Females	38.9±2.54	86.0±7.23	70.5±3.39	1.81	0.82	2.21
Total	40.3±1.90	87.2±5.38	64.3±2.36	1.60	0.74	2.16

* White population of New York State, aged 45 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

which exceeded the average for all natives of native parentage.

Involutional Psychoses

Natives of mixed parentage and natives of foreign parentage each had annual average rates of first admissions with involutional psychoses of 11.9 per 100,000 during 1949-1951. This rate greatly exceeds that for natives of native parentage, 5.4. Except for a few random variations

sequently, they had an average standardized rate of 33.4 per 100,000, compared with 16.3 for natives of native parentage, a ratio of 2.04 to 1. Based upon crude rates, the ratio was 2.20 to 1. Those of mixed parentage had a higher rate than natives of foreign parentage in the ratio of 1.27 to 1. In turn, the rate for the latter exceeded that of natives of native parentage in the ratio of 1.61 to 1.

The differences were also due in part

TABLE 12

Native white first admissions with involutional psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
25-29	..	..	..	..	..	..	1	0.1	0.1
30-34	1	0.1	0.1	1	0.2	0.3	3	0.3	0.2
35-39	20	1.8	1.5	3	0.6	1.2	28	2.6	2.3
40-44	132	11.6	10.7	58	12.5	25.2	122	11.4	12.4
45-49	209	18.3	19.6	81	17.5	70.4	225	20.9	32.6
50-54	278	24.3	28.9	116	25.0	62.5	298	27.7	51.4
55-59	269	23.6	34.9	103	22.2	66.3	222	20.7	52.7
60-64	146	12.8	23.0	65	14.0	52.4	112	10.4	38.4
65-69	70	6.1	13.7	28	6.0	28.2	49	4.6	23.3
70-74	16	1.4	4.7	8	1.7	12.0	11	1.0	7.2
75 and over	1	0.1	0.3	1	0.2	1.6	3	0.3	1.6
Total	1,142	100.0	5.4	464	100.0	11.9	1,074	100.0	11.9

at advanced ages, females had significantly higher rates than males.

Part of the excess by natives of mixed parentage was due to a higher proportion of those within the statistical limits of involutional psychoses. The rates were therefore standardized, and the results are shown in Table 13.

The highest age-specific rates occurred among natives of mixed parentage. Con-

to the greater concentration in urban areas by natives of mixed or foreign parentage. As an approximation to a direct comparison on this basis, the rates were standardized for first admissions from New York City. This resulted in an increased rate for those of native parentage, reducing the ratios of the rate to that for the other populations, but the differences remained significant.

TABLE 13

*Average annual standardized * rates of first admissions with involuntional psychoses to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

<i>New York State</i>						
	Of native parentage (a)	Of mixed parentage (b)	Of foreign parentage (c)	c — a	c — b	b — a
Males	10.8±0.66	24.6±2.32	17.8±1.04	1.64	0.72	2.28
Females	22.3±0.89	43.4±2.80	35.4±1.39	1.59	0.82	1.94
Total	16.3±0.55	33.4±1.82	26.2±0.87	1.61	0.78	2.04
<i>New York City</i>						
Males	13.1±1.24	21.7±3.12	16.4±1.24	1.25	0.76	1.66
Females	23.7±1.56	46.8±4.20	35.8±1.74	1.51	0.76	1.97
Total	18.1±0.99	33.7±2.63	25.6±1.07	1.41	0.76	1.86

* White population of New York State, aged 35 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

The standardized rate varied in New York State from a minimum of 17.9 among those of Italian-born parentage to 34.3 among those of Russian-born parentage and 31.3 among those of Irish-born parentage. Natives of English-born parentage had a relatively low rate of 20.4.

Manic-depressive Psychoses

There were 754 native white first admissions of native parentage with manic-depressive psychoses during 1949-1951, or an average annual rate of 3.6 per 100,000 population. Those of mixed parentage and of foreign parentage had corresponding rates of 7.1 and 8.1, respectively. In general, females had higher rates than males in all three nativity and parental aggregates.

Age-specific rates were higher for natives of mixed parentage than for those of native parentage. Among males, comparisons of groups of mixed and of foreign parentage

did not show definite trends. Among females, however, those of mixed parentage had higher rates than either of the other groups. Natives of foreign parentage had higher rates than those of native parentage.

Table 15 summarizes the rates for the three groups after standardization. It will be observed that the highest rate, 10.4, occurred among natives of mixed parentage. Those of foreign parentage had a higher rate than those of native parentage in the ratio 1.46 to 1. Contrary to the crude rates, however, the standardized rate for those of mixed parentage exceeded that for natives of foreign parentage by 25 per cent. Similar comparisons for New York City did not change the order of comparisons.

Natives of English-born parentage had a standardized rate of 4.4 per 100,000, compared with 5.7 for native whites of native parentage. Those of German-born parentage and those of Italian-born parentage had rates of 6.2 and 7.0, respectively.

TABLE 14

White first admissions with manic-depressive psychoses to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	2	0.3	*	1	0.4	0.1	..	..	..
15-19	27	3.6	1.7	11	4.0	2.9	12	1.6	2.3
20-24	86	11.4	5.3	29	10.4	7.5	49	6.7	6.1
25-29	97	12.9	5.9	38	13.7	11.1	76	10.4	7.3
30-34	87	11.5	5.9	38	13.7	12.7	112	15.3	9.0
35-39	112	14.9	8.4	34	12.3	13.4	132	18.1	10.8
40-44	101	13.4	8.2	35	12.6	15.2	127	17.4	12.9
45-49	67	8.9	6.3	28	10.1	14.0	76	10.4	11.0
50-54	52	6.9	5.4	22	7.9	11.9	60	8.2	10.3
55-59	45	6.0	5.8	15	5.4	9.7	45	6.2	10.7
60-64	38	5.0	6.0	10	3.6	8.1	29	4.0	9.9
65-69	25	3.3	4.9	9	3.2	9.1	6	0.8	2.8
70-74	10	1.3	2.9	6	2.2	9.0	6	0.8	3.9
75 and over	5	0.7	0.7	1	0.4	0.8	1	0.1	0.3
Total	754	100.0	3.6	277	100.0	7.1	731	100.0	8.1

* Less than 0.05.

TABLE 15

*Average annual standardized * rates of first admissions with manic-depressive psychoses to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

	New York State					
	Of native parentage	Of mixed parentage	Of foreign parentage	c	c	b
	(a)	(b)	(c)	a	b	a
Males	4.1±0.29	7.7±0.90	6.2±0.46	1.51	0.81	1.88
Females	7.2±0.37	13.1±1.10	10.4±0.57	1.44	0.79	1.82
Total	5.7±0.24	10.4±0.72	8.3±0.37	1.46	0.80	1.82
	New York City					
	Of native parentage	Of mixed parentage	Of foreign parentage	c	c	b
	(a)	(b)	(c)	a	b	a
Males	3.1±0.43	7.4±1.23	5.9±0.55	1.90	0.80	2.39
Females	6.4±0.58	12.0±1.46	10.4±2.24	1.63	0.87	1.88
Total	4.8±0.36	9.8±0.96	8.2±0.45	1.71	0.84	2.04

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 16

White first admissions with dementia praecox to all hospitals for mental disease in New York State, 1949-1951, classified according to parentage and age

Age (years)	Of native parentage			Of mixed parentage			Of foreign parentage		
	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population	Number	Per cent	Average annual rate per 100,000 population
Under 15	125	2.4	1.7	41	2.2	3.7	36	0.8	31.9
15-19	580	11.5	37.1	224	11.9	58.9	339	7.2	65.1
20-24	1,035	20.5	63.5	404	21.4	105.1	806	17.0	99.6
25-29	983	19.5	60.0	351	18.7	102.2	997	21.0	88.8
30-34	755	15.0	51.1	281	14.9	95.2	896	18.9	72.2
35-39	598	11.8	45.1	210	11.2	83.3	765	16.1	62.8
40-44	414	8.2	33.7	151	8.0	65.6	440	9.3	44.8
45-49	265	5.3	24.9	106	5.6	52.3	205	4.3	29.7
50-54	148	2.9	15.4	58	3.1	31.3	126	2.7	21.7
55-59	86	1.7	11.2	27	1.4	17.4	74	1.6	17.6
60-64	34	0.7	5.4	15	0.8	12.1	37	0.8	12.7
65-69	24	0.4	4.7	5	0.3	5.0	13	0.3	6.2
70-74	2	*	0.6	3	0.2	4.5	1	*	0.7
75 and over	2	*	0.5	4	0.2	6.4	2	*	1.0
Unascertained	..	..	..	1	0.1	..	2	*	..
Total	5,051	100.0	24.0	1,881	100.0	48.4	4,739	100.0	52.4

* Less than 0.05.

Neither differed significantly from the rate for native whites of native parentage. The highest rate, 12.2, occurred among those of Russian-born parentage. This must be attributed to the large proportion of Jews in this population.

Dementia Praecox

Natives of native parentage had an average annual rate of first admissions with dementia praecox of 24.0 per 100,000 during 1949-1951. Natives of mixed parentage had a rate of 48.4; natives of foreign parentage had a rate of 52.4. Among each of these groups, males had higher rates than females below age 30. This was reversed at all ages above 30.

Natives of foreign parentage had higher

age-specific rates than natives of native parentage, the relative excess decreasing generally with advancing age. Despite the lower crude rate, natives of mixed parentage had higher age-specific rates than natives of foreign parentage.

Standardized rates are summarized in Table 17. Natives of mixed parentage had a standardized rate of 59.2 per 100,000, significantly in excess of the rates for natives of native parentage and natives of foreign parentage. The rate of 49.1 for natives of foreign parentage exceeded the rate for those of native parentage by 49 per cent, compared with an excess of 118 per cent on the basis of crude rates. Standardization with respect to admissions from New York City did not affect the relative order

TABLE 17

*Average annual standardized * rates of first admissions with dementia praecox to all hospitals for mental disease in New York State, per 100,000 native white population, 1949-1951, classified according to parentage*

<i>New York State</i>						
	Of native parentage (a)	Of mixed parentage (b)	Of foreign parentage (c)	c — a	c — b	b — a
Males	32.9±0.83	57.4±2.46	51.6±1.33	1.57	0.90	1.74
Females	32.9±0.80	60.0±2.34	46.7±1.21	1.42	0.78	1.82
Total	33.0±0.58	59.2±1.70	49.1±0.90	1.49	0.83	1.79
<i>New York City</i>						
Males	41.9±1.57	60.4±3.48	51.2±1.64	1.22	0.84	1.44
Females	41.9±1.48	64.7±3.39	49.9±1.54	1.19	0.77	1.54
Total	41.9±1.08	62.7±2.43	50.6±1.12	1.21	0.81	1.50

* White population of New York State, aged 15 years and over on April 1, 1950 (in intervals of 5 years) taken as standard.

of the rates. We conclude that natives of foreign parentage had a higher rate of first admissions with dementia praecox than natives of native parentage.

Native whites of Irish-born and Polish-born parentage both had higher rates than natives of native parentage. Natives of Italian-born parentage had a rate of 36.3, which did not differ significantly from that for natives of native parentage.

Rates of First Admissions Among Foreign-born and Native-born of Same Parental National Origin

Native-born whites of specified parental origin (for example, Scandinavian-born) may be taken as belonging to the same ethnic stock as foreign-born of similar national origin. If race were the dominant factor in the relative frequencies of mental disease, the rates should be approximately equal for the two generations.

In general, however, the foreign-born had higher over-all rates of first admissions than the second generation of similar national and ethnic origin, with one exception. Foreign-born English had a lower rate than the second generation of English origin.

It is difficult to explain this exception, but we might speculate that it results from possible social selections among the emigrating English. The ratios of standardized rates of foreign-born to native-born of similar parental origin were as follows (based upon data for New York City): Ireland, 1.14 to 1; Norway, 1.10 to 1; Sweden, 1.48 to 1; Germany, 1.28 to 1; Poland, 1.34 to 1; Russia, 1.15 to 1; Italy, 1.17 to 1.

There are a few variations with respect to sex. Thus, among Norwegians, foreign-born males had a lower rate than native-born males of Norwegian parentage.

Among those of Swedish origin, foreign-born females had a lower rate than native-born. These variations are not statistically significant, however, because of the small populations.

More important are variations with respect to specific mental disorders. Thus, foreign-born Irish had a standardized rate of 38.1 per 100,000 population for alcoholic psychoses, compared with 26.6 for natives of Irish-born parentage. On the other hand, natives of Russian-born parentage had a significantly higher rate of such disorders than foreign-born. There were variations with respect to disorders of advanced age, in some cases rates being higher for foreign-born; in others they were higher for natives of foreign-born parentage.

Among the larger population groups, the foreign-born had higher rates of dementia praecox than native-born of similar parental origin. The relative difference was especially marked among those of German origin.

SUMMARY

This is a study of comparative rates of mental disease among the native white population of New York State. This population is divided into three classes—those of native parentage, foreign parentage, and mixed parentage, the latter consisting of one parent native-born, the other foreign-born. The rates were based upon the average annual number of first admissions to all hospitals for mental disease in New York State from October 1, 1948, to September 30, 1951. The population base was obtained from the federal census of population taken on April 1, 1950.

It should be noted that when parental nativity was unascertained, it was assigned by the Bureau of Census to the class of native-born. This clearly resulted in increasing the population base for natives

of native parentage, thereby decreasing the corresponding rate. At the same time, it decreased the base for the other classes of population, thereby increasing their rates.

There were 16,268 first admissions among natives of native parentage, or an average annual rate of 77.2 per 100,000. There were 5,932 first admissions among natives of mixed parentage, or an average annual rate of 152.7. There were 13,117 first admissions among natives of foreign parentage, or an average annual rate of 145.2.

These rates differ in part because of variations between the populations with respect to age and sex proportions. They also differ because of variation with respect to urban-rural distribution.

For reasons explained previously, it was necessary to approximate a constant urban density by limiting comparisons to New York City. Standardized rates were therefore computed with respect to first admissions from New York City, using as standard the white population of New York State on April 1, 1950, in five-year intervals beginning at age 15, or at other appropriate limits.

On this basis, natives of foreign parentage had a rate of 180.1 per 100,000, compared with 125.9 for natives of native parentage, a ratio of 1.43 to 1. The highest rate, 237.2, occurred among natives of mixed parentage. As noted previously, the rate for natives of native parentage is too low because of the manner of classifying those of unascertained parental nativity. Nevertheless, we must conclude that such native-born had a lower rate than the other two classes of population.

With respect to general paresis, the rates were 1.8 per 100,000 for natives of foreign parentage, and 1.7 for those of native parentage. The difference is not significant. In fact, native-born females of for-

eign parentage had a lower rate than those of native parentage.

In the case of alcoholic psychoses, there was no significant difference between natives of foreign parentage and those of native parentage. The rates were 10.6 and 9.9, respectively. Native-born females of foreign parentage had a lower rate than those of native parentage.

Natives of foreign parentage had a significantly higher rate than natives of native parentage with respect to psychoses with cerebral arteriosclerosis. The rates were 88.8 and 49.7, respectively.

There was a similar excess by natives of foreign parentage with respect to senile psychoses. They had a rate of 64.3, compared with 40.3 for those of native parentage.

With respect to involutional psychoses, the rates were 25.6 for natives of foreign parentage and 18.1 for natives of native parentage, an excess of 41 per cent.

Natives of foreign parentage had a rate of 8.2 with respect to manic-depressive psychoses compared with 4.8 for those of native parentage, an excess of 71 per cent.

There was a smaller excess by natives of foreign parentage with respect to dementia praecox, the rate being 50.6, compared with 41.9 for natives of native parentage. The excess amounted to 21 per cent.

It is clear that except for general paresis and alcoholic psychoses, natives of foreign parentage had higher rates of first admissions than natives of native parentage. We have shown that this held generally when the ethnic base was held constant, by comparing natives of foreign parentage

with foreign-born of the same national or ethnic origin.

It must be concluded therefore that the differences in rates of first admissions between the two generations are more likely to be related to social than to racial factors. Natives of native parentage who may be of third or later generations in the United States undoubtedly belong to a higher social and economic class than do those belonging to the second generation of native-born. The educational status of the native stock is also higher. It has been shown that the incidence of mental disease varies with such factors.

We conclude, therefore, that differences in rates between the groups of different parental origins are the consequence of variations in their cultural and social environments.

There is no clear explanation for the high rates among natives of mixed parentage. There is no reason for believing this to be the result of biological crossing, for the parental combinations are of a social rather than biological order. The classification is that of native versus foreign, which in itself is primarily a social description.

The reason for high rates of mental disease among natives of mixed parentage must therefore be sought in social criteria. Perhaps this will be explained in time by factors similar to those which are associated with high rates of delinquency among native-born of foreign or mixed parentage in the United States. This implies a conflict along cultural lines, and is not an expression of genetic factors.

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Two remarkable achievements of social therapy: The French psychiatric hospitals of Saint-Alban and Lannemezan

More than a century has passed since Esquirol wrote: "An asylum is a curative instrument; in the hands of an able physician it is the most powerful therapeutic agent against mental illness."

Although this scientific truth has been universally recognized, little has been done in this direction and co-ordinated "institutional therapy," with rare exceptions, remains confined to small research and university settings.¹ It was a most stimulating experience to visit a state hospital where every aspect of the patient's life was designed to remove the stigma of hospitalization. Here, the same patient was given a value role in a structured society, maintaining constant communication with the environment he had left and to which he would return.

This report deals with visits to two such hospitals in France, where we had the opportunity to attend some of the patient and staff meetings and to talk at length

with the directors. The unusual achievements in foreign hospitals are worthy of being called to the attention of American psychiatrists and other professionals, particularly those interested in ameliorating patient care in large public institutions.

The psychiatric hospital of Saint-Alban serves the population of La Lozère

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This paper was presented at the annual meeting of the Group-Without-A-Name, held at the Vermont State Hospital, Waterbury, Vt., in April, 1963.

¹ These groups, however, screen most of their patients.

(80,000 inhabitants), a department² situated in a poor mountainous region in the middle of France. It is staffed with three psychiatrists and four residents, has a capacity of about 600 patients, is divided into eight pavilions or units, and must accept all types of mental disorders, ranging from neurotic illnesses to the senile psychoses and severe mental deficiencies.

When its present director, Dr. I. Tosquelles, arrived 25 years ago, several hundred patients were confined in dilapidated buildings. Within these walls, secular habits had automated social life into well-documented stereotyped forms. An internal revolution was necessary, and the new director dedicated himself to this enormous task. The sequence of events, showing how a backward country hospital became a modern and active center for psychiatric treatment, could be very informative. Because of space limitations, however, only the broad outline of its actual functioning will be sketched here.

The hospital owes its originality to its social structure. Every patient is *de jure*, a member of a duly incorporated and legally autonomous club in terms of its relationship to the hospital administration. The club is supervised and assisted by a special section of the Mental Hygiene Society, called the Hospital Board, whose members include the hospital director, the chief psychiatrists, two delegates each from the Surveillance Committee³ and the local Mental Hygiene Society, as well as several hospital staff members; i.e., occupational therapists, nurses, etc.

According to a contract concluded between the hospital administration and hos-

pital board, the latter, through the club (that is, the patients), takes over the organization of recreation and work therapy. In return, the hospital agrees to grant a yearly subsidy, to provide the necessary room space, authorize its personnel to work for the club, and to allow the club to supervise the gratuitous distribution of tobacco furnished by the administration.

The club functions through four sections:

1. A general assembly
2. An executive committee
3. A work therapy secretariat
4. The permanent committees

The members of the *general assembly* are elected by each of the eight pavilions. The election procedure is determined by the physicians in charge, inasmuch as the group relationships will depend upon the patient population of each unit. The general assembly hears reports prepared by the three other sections, and approves the budget before its referral to the hospital board. The officers of the executive committee and the president of each committee are elected from its members.

The *executive committee* retains executive power and is composed of the committee presidents and one delegate from each unit. It supervises and co-ordinates the work of all committees and recreation activity.

The *work therapy secretariat* is made up of eight patients elected at the unit level and has the responsibility of planning and co-ordinating work activities. Since work represents "the focus of the day's activities" (3) in this setting, some explanation of this organization is necessary.

Each pavilion houses at least one shop where varied handiworks are produced (from delicate pieces of embroidery to wrought iron). Each operates on the

² The "department" is a French administrative unit; there are 90 throughout the country.

³ The director of a psychiatric departmental hospital reports to a Lay Committee.

model of a co-operative, keeps its own accounts, pays its workers, and sells its products directly or through the secretariat. The hospital itself is a good customer; for instance, it purchases all of its stationery from the printing shop. Trading within the club also accounts for an important part of the transactions; for example, the machine shop sells tools needed by other shops. Lastly, outside buyers are solicited. At one meeting it was decided that two of the old ladies in one pavilion would put up their unsold goods for sale at a market in the vicinity. The group-owned station wagon was to be requested for that day.

Patients not employed in the shops operated by the club are assigned to help in the laundry, the kitchen, etc., and are remunerated by the hospital. A levy of 10 per cent on all profits or wages is made to the club treasury for administrative expenses, special purchases, rental fees for films, etc.

The *permanent committees*, five in number, oversee the management of the store, the newspaper, sports and excursions, the evening recreation programs and the motion picture club. Each committee, composed of 16 delegates (2 from each unit), meets monthly. As noted before, the executive committee holds a veto power on suggestions or requests coming from the permanent committees. The delegates, however, have the responsibility of working out a good liaison between the executive committee and their committee on the one hand, and their pavilion on the other hand.

Unremitting efforts have been made to train hospital personnel and foster their enthusiasm, a *sine qua non* of success. There is a regular and continuously operating teaching program. A monthly staff technical bulletin is published; it contains high caliber articles devoted solely to prac-

tical and theoretical problems of the institutional therapy program at Saint-Alban. The nonmedical staff has created a cultural group which has its own Ciné Club and invites lecturers to talk on psychiatric and parapsychiatric topics.

The small society of Saint-Alban does not harbor the fallacious pretension of being democratic; it is meant primarily to be a therapeutic instrument and as such remains under the vigilant control of the medical staff. Indeed, its efficiency rests on the active and ubiquitous presence of an experienced medical staff, trained in group work and all forms of group therapy. At least one psychiatrist attends about every meeting of the club; daily staff meetings (with doctors and nurses) take place in both male and female services. Monthly staff meetings are conducted by the physician in charge of each pavilion. Psychodrama and group psychotherapy sessions are held for patients, as designated by their doctors.

At the occasion of these numerous contacts and interchanges, pathologic reactions and attitudes are pointed out and analyzed either in the group or in the privacy of the psychiatrist's office.

The creator and main driving force of this program attaches little importance to the details of Saint-Alban's ever-changing social structure as it adapts itself to the multitudinous influences of a living society. "I do not believe," said Dr. Tosquelles, "in the magical therapeutic efficiency of this complex scaffolding which requires so much energy from the whole hospital. However, I find completely absurd the idea of treating a wound by internal medicine if it is left without a dressing. Now, if I do not know, and nobody knows, which are the genetic and functional causes upon which we must intervene, and we intervene like everybody, I know that something is dis-

turbed at the interpersonal level of our patients' lives and that remedies must be applied there" (6).

That there exists more than one model of therapeutic community or of institutional therapy, as when a whole hospital becomes such a community, is demonstrated by the Psychiatric Hospital of Lannemezan. Here, without the somewhat complex social apparatus of Saint-Alban, a milieu most favorable to the re-establishment of normal interpersonal relations has been created.

Lannemezan lies in the foothills of the Pyrenées Mountains; it was built in 1930 and houses about 1,100 patients. Under the energetic direction of Dr. Henri Ueberschlag, gradual landscaping of the grounds and remodeling of the buildings have made this hospital one of the most beautiful and modern in all of France.

A remarkable feature is the great attention devoted to the very chronic schizophrenic, the mentally deficient adults and children, and even senile patients. While tremendous and successful efforts made during several years under the direction of Dr. Ueberschlag had transformed the hospital social structure, this hard-core group had not been penetrated, and the new social structure more or less seemed to be responsible for its splitting apart from the main stream of the hospital (5, 8). It was a weight breaking the forward movement of the community, and, therefore, a decision was made to tackle the problem on two fronts:

1. This group was actively drawn into the community with the help of less chronic patients. For instance, the latter took the older people for carriage rides through the vast and spacious hospital grounds. These activities were not claimed to be therapeutic per se but broke the barrier, to a certain extent, between the

two classes of patients. Moreover, those acting as "staff members" gained a certain amount of self-esteem.

2. Elaborate technique were and still are experimented with, with the goal of creating and developing object relations in emotionally regressed or intellectually deficient patients. The accent was placed upon muscular exercises of every type, from the re-education in walking to sleep conditioning. In a first stage, the patient worked alone with his monitor and only later did he join the group. Effects were devoted to making all of this "exercising" as similar as possible to "playing" (music, bright colored walls, etc.), following the hypothesis that a very regressed or retarded patient needs to play like a young child in order to progress to the next developmental stage. Another important detail is represented by the presence of mirrors as the patient slowly comes to learn and accept his self-image. To Dr. Ueberschlag, acceptance of self-image is of paramount importance. Needless to say, the monitor's attitude plays a role not to be overlooked.

Sports, as a socially accepted form of playing for adults, are used as a third step for resocialization. Most patients take part in sports and can even learn judo, thanks to the presence of a psychiatrist who is adept at this noble sport.

Games do not represent everything at Lannemezan, and the patient who improves has access to a well-integrated small society, ready to offer him a specific role. A most original aspect of this hospital derives from its amusement park, built entirely by patients, owned and managed by them through a club. It can attract as many as 2,000 people from the community on a bright summer Sunday. The drawback of this particular type of seasonal occupational therapy is more than compensated by the sociologic revolution it has

produced. It has broken down the barriers between hospital and community, instead of putting the mentally ill in a secular position of dependency. The hospital is no longer an object of dread, and no better example can be reported than this threat to children frequently heard in the homes of Lannemezan: "If you are not good, you won't go to the hospital on Sunday!"

The integration of the psychiatric hospital into the community is being carried further. At the time of our visit a golf club owned and operated by the patients had just opened. The construction of a church on the grounds has been approved, and will function both as hospital chapel and parish church for the vicinity.

DISCUSSION

Can these two French achievements have some practical bearing on the recent debate concerning the role and functions of mental hospitals? These examples demonstrate, we believe, that the psychiatric hospital, when properly utilized, remains an excellent economical and centralized place to treat the mentally ill. The goals of these two institutions have been achieved in large measure by the introduction of large scale remunerative and productive work therapy, as well as by converting the hospital into a total socially, active and integrated group.

Such a transformation is hampered less by financial and space limitations than by the need for appreciation and utilization of group dynamics, which is peculiar to the structure of large institutions. The previous daily life at these hospitals resembled that of the "arrested" societies described by Toynbee (7). In drawing the analogy further, just as these civilizations were stopped in their growth by too great a "challenge" either from nature or man, so these pa-

tients are severely "penalized," to use Toynbee's terminology, both by their inherent biological defenselessness and by the societal pressures and rejection. Only a psychodynamic approach—*The Vermont Story* provides such an example (1)—will allow the dominant patient class to yield some of the pressure it exerts on the dominated group.

These accomplishments take time. In Saint-Alban, for instance, the main problem was not that of hiring personnel for new shops, but rather of changing the dinner hour from 4:00 P.M. to 6:30 P.M. It took years to convert nurses and attendants from wardens to therapists. But the staff now has a great satisfaction in working with the patients, instead of standing about for hours jangling a ring of keys.

One of the lacunae of both programs, admittedly still incomplete, is the lack of integration between hospital and outpatient followup, even though the patients are seen in the community by hospital doctors. But the French practice of "sector-psychiatry" has not as yet been instituted in these rural areas and the teams are too small for the task, not too well co-ordinated and, most important, they lack the mobility needed for rural mountainous regions.

This is not the place to advocate the virtues of work therapy for psychiatric patients nor to expound upon the conditions under which it is just a more elegant form of traditional occupational therapy. There is an abundant literature on this subject (2, 4). It is essential to point out that paid work therapy and productiveness⁴ do not, of necessity, exclude each other. On the contrary, there is, to a certain degree, a reciprocal causal relationship between

⁴ Obviously, we do not use this word in the sense of competitiveness in regard to a given market. The expression "production for consumption" might better define what we mean.

both. A patient works better when a sense of usefulness and profit is attached to his activity. Conversely, such usefulness and financial reward are, in our culture, some of the elements of therapeutic work. The latter must always be integrated into the total approach to the patients' treatment, and prescribed like drugs or psychotherapy. (These forms of treatment, incidentally, are widely used in both hospitals, as already indicated by Dr. Tosquelles.) Its effects, as well as the patients' reactions, must be thoroughly analyzed.

When these conditions are fulfilled, it would seem more appropriate to organize the work for the betterment of the patients' material condition and the lessening of the hospital's financial burden. In this manner, the patients of Saint-Alban purchased a bus for themselves, while the amusement park of Lannemezan was built without additional funds from the administration.

However, behind these plain facts, much more is concealed. There was a complex group interaction which led to the activation of these projects. They also symbolized vividly the coming back of the "lunatics" to a society which had excluded them from the community, banished them to the countryside, and fearfully relegated them behind bars.

Such changes cannot be made without administrative flexibility and decentralization of power in order to avoid paralyzing any original ideas rising from the lower echelons. Mobility in all directions is of great importance.

The social setting in these hospital communities, adapted to the local needs and problems, may not be applicable, as such, to large cities. The timeworn criticism of such operations is that "They are good

in isolated communities but will never be possible in large urban centers." The same has been said about Gheel. However, psychiatry has reached the stage where it must cast off its time-seasoned stereotyped defenses against all change. If it is to be rightfully classed among the medical specialties, maximum effort must be exerted at all physiological and sociologic levels. Its dogmatic inflexible position of the past has prevented the adoption of new procedures from one setting to another. Nowhere do we propose that the novel social structures described herein can be adapted in toto to any other hospital. However, we believe they can be modified to fit the local needs. *If we ask patients to change, then psychiatry must be equal to the change as well.*

SUMMARY

The social therapeutic programs of two French departmental hospitals, Saint-Alban (Lozère) and Lannemezan (Hautes-Pyrénées) have been described. Consideration has been given to the values of this form of treatment. Some comments have been made concerning the resistances one may encounter in attempting to initiate this type of change.

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Family organization on a modern state hospital ward

INTRODUCTION

As Jackson and Weakland (1) once said, treatment of a psychiatric patient *necessarily* involves dealing with members of his family. Even excluding members of the patient's family from the therapy involves dealing with them and the question really is not *whether* the patient's family is to be dealt with, but *how* they are to be dealt with. One manner of dealing with this problem is in wide use in this country: In the large state hospital the family of the newly admitted patient is used as a source of information by the intake worker. The patient's history is primarily made up of the anamnestic data extracted from his family.

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Then, during the main phase of the patient's hospitalization, the family is seen more as a hindrance than a help in treating the patient, and they are kept at arm's length as much as possible. They usually are ashamed to be seen there and find their contact with the hospital uncomfortable. Shortly before the patient is discharged from the hospital, the family is again brought into the picture in an effort to prepare them somehow for the return of the patient. Not infrequently the social worker then reports that in the meantime the family has become quite discouraged and detached, and only with difficulty can be persuaded to take the patient back. Likewise, the patient feels that he has lost his room and his place in the family unit; he feels estranged and discouraged and cannot envisage his return to the home as a pleasant and desirable event.

At the other extreme is the school that subjects all family members to intensive,

sometimes analytic therapy, either individually with different therapists or in various groups—father in a fathers' group, mother in a mothers' group, siblings in a young people's group—with only occasional conferences with the various therapists. The members of the family are treated as separate patients, and cohesion of the family as a unit is disregarded and often lost.

Sometimes it almost seems as if the inhabitants of some of the poorer countries, in certain respects, were better off than the citizens of this richest country of the world. When an Indian psychiatrist visited our insulin research and teaching and family therapy unit at Creedmoor State Hospital and observed the work of our family organization, he saw nothing remarkable in the fact that the family of the hospitalized patient should keep in close contact with him and try to take care of him as much as possible while he was in the hospital. This Indian colleague told us that in India the family comes to the hospital with the patient as a matter of course and stays near him for as long as he remains in the hospital. They set up their tent near the hospital, where they cook for the patient, wash his clothes and tend to his other needs. Of course, this is done out of sheer necessity because there are hardly any attendants and only very few nurses, but the patient certainly is spared the anguish of the psychiatric patient in our modern society, who may feel himself an outcast of society, abandoned by his family and friends in a place far removed from the environment he was used to (7).

INTEGRATION OF THE FAMILY IN THE PATIENT'S TREATMENT PLAN

The authors' goal has been to integrate the family into the patient's treatment plan in such a way that the patient's hos-

pitalization can be expected to yield optimal benefits for both patient and family.

In an earlier paper (2) we traced the development of this idea from 1951—when the early didactic Sunday meetings of all patients and their families with Dr. Laqueur were begun—to 1961, when the families organized themselves in a committee along the lines of a Parent-Teacher Association, with the objective of collecting funds for recreational and occupational therapy facilities for the patients.

The ward in Dr. Laqueur's charge was, in 1951, a 17-bed insulin ward which gradually developed into the 100-bed intensive treatment ward of today with 50 patients on insulin coma therapy and the other 50 on combined electro-convulsive therapy and chemotherapy, or chemotherapy alone. Thus the core of the ward even today consists of a group of patients in insulin coma treatment who stay together for at least four to five months. The organization of the families, even the ones of short-term patients, is no doubt greatly facilitated by the presence of this nucleus of long-term insulin coma patients' families.

CREATION OF "AUXILIARY COUNCIL 40"

About two years ago, this family committee, with the approval of the Department of Social Welfare of the state of New York, was incorporated under the name "Auxiliary Council 40," named after the 40 buildings at Creedmoor State Hospital.

Its charter lists as the purposes of the organization, among others: "to help provide the therapeutic atmosphere believed to be essential to the recovery of patients in state hospitals, for which the materials cannot now be provided by the state budget; to act as a central distributing point for constructive information and guidance to families of psychiatric hospi-

talized patients; to set up group-therapeutic operations for these families; to organize fund-raising programs to provide for the above activities."

Today most state hospitals work with large volunteer organizations which assist them with recreational and ward-beautifying projects. Our hospital is no exception. A volunteer organization under a state official began to function at Creedmoor State Hospital in 1955, and several hundred ladies are today engaged in these recreational activities. Thanks to the understanding attitude of our hospital administration, the then already existing, though not yet formally incorporated family committee of our ward was exempted from absorption into this general hospital volunteer program under a kind of "grandfather clause."

The activities of the traditional hospital volunteer organization are by definition impersonal, and it is even clearly stipulated that volunteers may not serve their own relatives in order to avoid improper privileges for the more fortunate patients.

In conscious contrast to these entirely understandable and laudable principles, Auxiliary Council 40 is structured as a self-help organization of the families whose motives are highly personal; namely, the wish to help one of their members who is a patient on our ward. These families do not organize themselves because they want to make their services impersonal, but because they believe that as a group their help can be more effective than if they try to help individually.

Through their close contact with staff and patients, our patients' families had been very much aware of the factors that necessarily hampered and limited the functioning of our ward as the therapeutic community as which it had been set up.

They saw us struggle with the shortage

of personnel, with lack of recreational and occupational therapy materials; they knew that often for weeks on end patients could not be taken out into the open air, nor could they participate in sports for lack of an attendant to accompany them; they watched us start projects of occupational therapy, even research projects, only to have them interrupted by an unforeseen and unforeseeable lack of help because some of our attendants had to help out on another ward where there was even less assistance than on ours.

The families realized that these conditions were not the fault of any individual or of the hospital administration as a whole, but that a state budget of approximately \$6.00 per day for the average state hospital patient, or even approximately \$8.00 per day for an insulin coma patient does not buy the help necessary to keep a therapeutic community going.

They finally came to the conclusion that what was needed was not an occasional individual contribution to a Christmas party or a summer picnic for the patients, or the donation of some single piece of equipment that somebody could spare from home, much as such help always had been appreciated by us, but that they could render a more systematic assistance if they were formally organized and as an organization could start fund-raising programs.

Much as we admire people who work in impersonal charitable programs for a grey mass of anonymous victims of heart disease, or multiple sclerosis, or alcoholism, or mental disease, it seems only human that people who are personally involved in the cause for which they try to raise funds, such as our patients' families, work with special fervor and dedication.

Auxiliary Council 40, moreover, does not only provide help for the present but has been able to foster its members' interest

in our scientific work to such a degree that funds have been and are being raised outside the hospital for research projects that can yield results only in a more remote future when the patients of the families who collected the money will no longer be on our ward.

As far as we know, the usual hospital volunteer organizations have not been able to inspire their members to a similar degree.

Auxiliary Council 40 is, of course, like the traditional volunteer organization, conscious of the danger that more affluent families might tend to provide their patients with greater material privileges than their fellow-patients and that this would create tensions on the ward.

The executive officers of Auxiliary Council 40 therefore make certain that all contributions, whether large or small, lead to services that reach all patients equally, and that the only criteria for different treatment of individual patients are their medical and psychiatric needs. The joint meetings of staff, patient committee and family committees, and the open Sunday meetings of all patients and families with Dr. Laqueur, act as a good system of checks and balances in this respect.

FUNCTION OF AUXILIARY COUNCIL 40

Auxiliary Council 40 has a three-fold function: (1) to preserve the family as a functioning unit, despite the physical separation of one of its members, the hospitalized psychiatric patient; (2) to contribute to the therapeutic milieu in the hospital, and thereby hasten the patient's discharge and increase his chances for a full rehabilitation in the world outside the hospital; (3) to provide funds not only for material improvements in the care of patients in the state hospital but also for special research grants.

1. Preservation of the Family Unit

When a patient arrives at the psychiatric hospital, our concern as physicians and as staff is, in the first place, quite naturally for him. We must not forget that not only the patient's life has been disrupted by his sickness and hospitalization, but that before he came to the hospital he very often had been a very disruptive force in the life of his family.

Resentment, but also quite often relief is felt by the patient as well as his family at the prospect of their being separated from each other. It cannot be denied that not infrequently families are rather content to be held at arm's length during the treatment period of their patient. This may and often does lead to a detachment of the family from the patient that can destroy the cohesion of the family unit permanently so that the patient at the time of discharge has "no place to go," if not physically, at least psychologically.

Every psychiatrist presumably comes across cases where the destructive influences of a patient and his family on each other are so strong that such permanent detachment must be seen as a solution to an otherwise insoluble problem, but such cases, in our experience, are extremely rare.

As a rule, we believe that every possible effort should always be made to improve relations among the members of a patient's family, and only if all efforts to help them to a better understanding of their mutual problems fail should a separation of the patient and his family be accepted. If in our society the normal individual sees the family as shelter, security and reinforcement of himself, the psychiatric patient and ex-patient needs this feeling even more when he returns to the outside world, and he even needs it while he is still in the hospital.

We try to achieve an improvement of relations in the family mainly through our program of Multiple Family Therapy. Groups of four or five families, including their hospitalized member, meet once a week with a therapist for a group-therapeutic session of one hour. A new family is brought into one of these groups as soon as possible after their patient's admission to our ward and they continue in this therapy until the patient's discharge.

An improvement of communication within the family is almost always achieved and quite often it is even possible for the members of the family and the patient to gain an understanding of the psychodynamic mechanisms underlying their behavior and their reactions to one another. Papers describing this Multiple Family Therapy in detail were presented at the Annual Meeting of the American Psychiatric Association in St. Louis, Mo., in May, 1963 and at the First International Congress of Social Psychiatry in London in August, 1964 (4, 5, 6).

Although Dr. Laqueur always held meetings with individual families and their patients as the need to deal with special problems arose, the Multiple Family Therapy program could certainly not be carried out on the present scale without the financial help from the families.

Five clinical psychologists, a psychiatric research nurse and a senior psychiatrist are engaged in conducting these group meetings, many of which are held in the evening, after hospital work hours, or during weekends because neither would enough personnel be available nor could all families attend meetings during working hours. For these evening and weekend hours personnel are paid out of a grant made by Auxiliary Council 40 for this project, rather than directly by the participating families.

The participation of the family together with the patient in these group sessions gives the patient the assurance that his family "cares," and this feeling is reinforced by the other activities of the family committee that will be described later in this paper.

2. The Families' Contributions to the Therapeutic Milieu

The family committee is most active in its endeavor to contribute to the therapeutic milieu on the ward in co-operation with the ward staff and the patient government. Several committees, dealing with special projects, have been formed within the family organization. In weekly meetings these committees and the patient government work closely together in planning recreational and occupational therapy activities for the patients and providing the material means far beyond anything the state can furnish.

Pool and ping pong-tables, cards and games, ward libraries, radios, phonographs, records, TV sets, sewing machines and typewriters have been provided partly with funds collected by the family committee and partly by donations of equipment obtained through the family organization.

Weekly showings of full-length motion pictures, weekly parties and dances, music and dance lessons, arts and crafts classes, a drama club—have all been maintained with the help of the family organization.

Clothing, cosmetics and cigarettes are donated for patients without funds or families.

The Friday night parties are a typical joint undertaking of the patient government and the family committee. Food plays a major role, partly because for the patients on insulin coma therapy it is, after five days of restricted diet, the first

evening in the week they can eat freely, and for the other patients it is a welcome change from the inevitable monotony of food in a big institution.

A great deal of planning goes into the menu, which mainly consists of sandwiches and salads. Patients who are well enough to go out are delegated to do the shopping in a nearby supermarket on Friday morning. Members of the family committee provide transportation and accompany these patients on their shopping trip. A good part of the rest of the day goes into preparations of the sandwiches and other party fare, done by the patients without any outside help.

In the evening, members of the family committee often act as volunteer deputy supervisors for the party to leave hospital personnel free for other tasks. In fact, the Friday night parties could not take place at all if supervising personnel were not supplemented either by members of the family committee or by attendants and nurses on their free time, for whom the family committee provides the funds.

The motion pictures for the weekly showings are chosen by a patient committee without interference from the family organization. The latter only provides the funds for renting these films.

The donation by the family organization of several typewriters made it possible to start typing classes for interested patients; this may provide them with training in a skill that may prove very useful when they leave the hospital and return to the community.

Aside from this material assistance, the family organization assists the staff with the creation and maintenance of a psychologically beneficial milieu on the ward. Rules and regulations for the patients are discussed and explained to newcomers by family committees. Representatives of

the family organization take part in the weekly meetings of staff and patient government in which weekend passes are decided, and the family representatives take it upon themselves to notify the families of patients who will have passes for the coming weekend.

Information and orientation for families of newly admitted patients is furnished by the family committee, and these new families are guided to an understanding of the active therapeutic principles underlying the operation of our ward.

The family organization sometimes wards off complaints of individual families to the hospital administration and, if they are considered important, they will be handled jointly by staff and family organization; if they are minor and based on an erroneous concept held by the complaining family, the family committee may handle them with their own explanations and discussions, thereby saving the doctors' and the nurses' time.

Thanks to the spirit of sincere co-operation for the welfare of the patients prevailing between staff and family committee, we can say that the family organization never became a pressure group. On the other hand, there is no doubt that the family organization fulfills, in addition to other functions, the role of a watchdog committee.

Our staff know, of course, that patients take their complaints to the family committee and that such complaints will eventually be fully and freely discussed with the whole ward team, including Dr. Laqueur. It can be assumed that this has something to do with the quality of our personnel, although it is, of course, their initial willingness and interest to work in a unit like ours, and the training they receive there, that give them a more psychiatrically-oriented, therapeutic attitude

than most state hospital personnel possess.

In a previous paper (3) we spoke of the four corners of a field of forces: namely, the patient, his family, the hospital and the peer group (by which we meant his fellow-patients in the hospital), and later, in the outside world, siblings, friends, fellow-employees, social acquaintances, etc. To this is now added a fifth corner; namely, the families of his fellow-patients, who occupy in the patient's life a place different from his own family and different from his peers. They are figures invested with a varying degree of authority for the patient, and his relatively close contact with them provides him with an opportunity to work through his problems with authority in the sheltered atmosphere of the hospital.

3. Special Research Grants Provided by the Family Organization

Funds are collected by Auxiliary Council 40 from the organized families themselves, but also in great measure from their friends and through their own fund-raising programs.

These funds are channeled in two ways:

(a) for the recreational and occupational activities described earlier—to buy equipment, materials, to pay for supervision of evening parties, film showings, etc.

(b) for special earmarked research grants which finance several projects, such as: psychiatric studies of patients during the period of their awakening from insulin coma; remotivation studies for autistic, withdrawn patients; electric monitoring for insulin sensitivity studies; project "open air" (with funds provided by Auxiliary Council 40 personnel are hired in their free time to take patients out for games, or go on a picnic). Studies are made whether and to what degree the patients' be-

havior changes through such systematic physical activities. Project "esthetics" (exhibits of good reproductions of paintings and photographs are planned on various themes, such as France, The Renaissance, modern art, the family of man, etc.) Again, systematic observation will reveal whether and what influence such experiences may have on the patients. Last, but not least, the already described Multiple Family Therapy program must be mentioned.

All funds are administered by the Research Foundation for Mental Hygiene, Inc., under the control of auditors for the state of New York.

SUMMARY

In keeping with the modern trend of making the psychiatric hospital part of the community, instead of a dumping place for undesirables, the families of patients on our 100-bed active treatment ward at Creedmoor State Hospital organized themselves in an Auxiliary Council 40. This Auxiliary Council 40 proves to be of great value to the efficient functioning of the ward as a therapeutic community.

Aside from the material assistance provided by the family organization, which goes far beyond the capacity of the state budget, we consider the integration of the families in the ward operation during the entire period of the patient's hospitalization to be of the greatest therapeutic value.

In contrast to the usual style of purely recreational activities sponsored by the traditional hospital volunteer organization, our family organization has developed its own style, more geared to a psychodynamic understanding of the patients' and the families' needs.

The families' active work in and for the ward keeps the patients constantly aware of their families' concern for them.

Families and patients are helped to preserve their dignity as human beings through the opportunity to co-operate for a common good instead of feeling that they are being manipulated and controlled by the hospital authorities. Through this co-operation both patients and families, are prepared for the patient's return to society, and this experience helps him to regain his place as a responsible member of this society.

Auxiliary Council 40 is at present engaged in creating chapters on other wards throughout Creedmoor State Hospital and it is hoped that this organization will eventually also spread to other hospitals in New York state.

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A perspective on the function of the psychiatric halfway house

In the past few years there has been a rapid expansion in the range of facilities for psychiatric rehabilitation. To the long-established foster-care services have been added day-care centers, night centers, ex-patient clubs and sheltered workshops.

Although it has its roots as far back as 1781 in an "establishment for the insane poor" in Britain (7), the halfway house has only recently made any real impact on the psychiatric scene. During 1960 seven halfway houses could be identified in America (14). By the early part of 1963 this number had increased to around 60, and there is every indication that during 1964 it will exceed 100. This pattern of

expansion appears to be much the same in Britain.

Despite this rapid growth, there is little accumulation of any coherent rationale for the formation of this type of institution. The function of halfway houses is usually explained as "providing a bridge between the hospital and the community."

However, as with any bridge, it must be clear what areas must be joined, for what particular purposes, by what methods and materials and when it is best to start building. It is not sound to build anywhere and for no better reason than that it looks well or panders to local pride of ownership.

The time has surely come when the mere fact of continued and increasing demand for particular psychiatric facilities cannot be regarded as their sole *raison d'être*. Nor, indeed, is one in a position to evaluate the effectiveness of halfway houses without some criteria against which to measure. Broad, time-honored evaluative indices, such as reduction of symptoms, length of

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stay, occupational adjustment may have little pertinence in demonstrating the effectiveness of these particular institutions. What research and inquiry has done in this mode tends only to underline the heterogeneous nature of such houses—in staffing, selection of patients, activities and in declared aims.

The purpose of this paper is to focus on one present gulf that exists between community and hospital and for which the halfway house may provide an effective and timely bridge. The gap is that which exists between the way the patient is regarded in the community and in the hospital setting, and which is likely to result in a considerable role confusion for the patient. It is becoming increasingly apparent that the role demands of the community are very different from those which the patient finds in the psychiatric hospital. On leaving the hospital he is likely to find that the roles he has acquired there are not acceptable for adequate reintegration with the community. If we can identify the origin and nature of this confusion, the type of bridge construction most appropriate to deal with it may become more apparent.

FROM COMMUNITY TO HOSPITAL

The vulnerable individual in the community exhibits behavior which infringes the norms of the subculture in which he lives. As this behavior deviates, other individuals in the immediate social environment (family, workmates or neighbors) issue sanctions against its perpetrator and increasingly ostracize him from normal social intercourse. During this process the individual may present himself in some guise to formal agencies of the community (medical, legal, social or religious) to seek relief from these covert or overt pressures.

Alternatively, if this behavior persists and exceeds the toleration limits of people in the subculture, or there is any reduction in their toleration threshold, then stronger and more overt pressures are exerted to extrude the individual from the community by more direct approach to formal community agencies. Through the selective judgmental systems of these agencies the individual may come into psychiatric care and hospital. This final process confirms the individual in a deviant role.

Little is currently known of these identifying and judgmental processes, although an increasing number of studies are being directed to this general problem. Differences between the perception of the "psychiatric deviant" by the lay community and by the psychiatrist have been demonstrated by Star (13). When brief psychiatric case histories of typical disorders are presented to members of the general public there is little uniformity in identifying the person portrayed as ill or in need of care. The only general exception to this is where the case histories indicate extreme violation of behavior norms, as in violence or threat of violence against other persons.

This discrepancy of identification and the mode of reaction as between lay and professional members of the community becomes even more apparent when examined at a family level. Yarrow, *et al.* (16), in a retrospective study, have shown that wives of hospitalized psychiatric patients initially perceived their husbands' behavior principally in terms of physical problems or complaints, deviation from routines of behavior, nervousness, irritability and worry. Their interpretation of this behavior tended to be couched in moral sanctioning terms of weakness, laziness, ineffectuality, absence of willpower, or in physical problems. The husbands' difficulties were rarely seen as indications of

mental illness or even as emotional problems.

Not only, then, does the vulnerable individual have to cope with his own distressed feeling state (with the insecurity and feeling of isolation that this engenders); he is also subjected to a sanctioning process that casts him in a deviant role, alienating him from normal social intercourse and creating a self-image of an abnormal person. This process of alienation before he comes into psychiatric care may often extend over a long period of time and become well-entrenched. Linn (9), for example, has shown that a significant minority of hospitalized patients had been perceived by their families as "being changed," as "acting bizarre" for over two years before some critical event triggered their ultimate rejection, culminating in hospitalization.

It does seem apparent that at the time he enters the psychiatric hospital the patient has a deviant, or at least a confused identity. In the long-drawn-out distorted interactional process, his normal social role and attendant skills have become lost to the patient, and the community has built up entrenched patterns of rejection and hostility toward him.

There is evidence (10) that even on hospitalization the community frequently persists in the denial that the patient is ill in any sense and still seeks some punishment or moral sanction against him. It is to this same scene that the patient has to return when he again leaves the confines of the hospital.

THE PATIENT AND THE HOSPITAL

The social environment of the hospital and its effects on its patient members has become the focus of considerable study. (See, for example, 4, 5, 6, 12.) It is now apparent that within these organizations there are many pressures on their mem-

bers, both patient and staff, to act in accordance with a complex of value and behavior systems.

The staffs of these organizations bring to the situation a philosophy of treatment which rests on the belief that a patient must accept his illness in the terms prescribed by them before any effective treatment can be given. The judgmental mode of the community is replaced by "clinical permissiveness" toward deviant behavior, stemming from a principal concern about the "inner experiences" of the patient. Thus, "staff members are expected to "understand" and "accept" a patient's behavior, no matter how unpleasant, as a manifestation of her illness, rather than as a performance of a "bad" person" (12). There are attendant dangers in this approach, however, for it has been demonstrated that acceptance of symptomatic behavior may reinforce it (11).

Any incapacity of the psychiatric patient is assumed to permeate the whole of his being and his activities. Direct responsibility for his actions tends to be denied to the hospital inmate: his daily activities are tightly scheduled; and he is often given aimless and menial tasks. The occupational therapy of basket and rug-making, uncritically applying the approach of physical medicine, attempts to put a cloak of "therapeutic" benefit on some of these daily activities (15). The most persistent rationale for this situation is that the patient would find any greater responsibility impossible. These features, however, are likely to continue until the date of his departure, when he is presumably expected to become quite suddenly a fully responsible adult member of society, capable of carrying out his work adequately and often providing for his dependents.

The other patients also exert pressures on the individual to conform to their own

particular mores. He becomes part of a complex patient hierarchy, and he is expected to adopt prescribed modes of behavior and reaction toward other patient members and staff. Deprived of a strong social identification on entering the hospital, the individual may rapidly accept the complex patient role that this new environment forces upon him; indeed, he may become increasingly dependent on such a role as a mode of adjustment to the world. However, this adjustment is only likely to be effective in the hospital environment and so may create a dependency on such an environment which increases as the length of time in hospital increases, and, in turn, predisposes an increase in the length of stay.

FROM HOSPITAL TO THE COMMUNITY

In his new role the patient, on discharge, emerges once again into a community which does not provide the conditions in which this role is relevant or effective. Certainly during the period of short-term hospitalization the community attitude is unlikely to have modified, and the alien regard is likely to undermine quickly any attempts of the patient to build a socially normal role for effective interaction. Thus, the cycle of inadequacy, symptomatic behavior, hospitalization is likely to be set off again.

Brown, *et al.* (2), for example, have shown that a significantly higher proportion of schizophrenic patients, returning from the hospital to homes where key relatives exhibit emotion, hostility or dominance, deteriorate in behavior more readily and become rehospitalized. This deterioration is independent of the mental and behavior state on original hospital discharge.

In the case of the long-term patient, the longer duration may act as a sanction to

modify the perception of him by the community so that they may confer upon him a sick status. Thus, their attitude toward him may become more akin to the protection offered to the physically infirm and helpless, and their toleration of any deviant behavior may increase. Such a patient may survive in the community without becoming an effective member of it, however.

It may well be that the recent marked increase of patient re-referral to mental hospitals reported in both Britain and the United States is, in part, a function of the current reduction in the initial duration of hospital stay. In the past, the community could accord the long-term inpatient a sick status and waive their standards of normality. With the present shorter hospital stay the attitude prevailing before hospitalization is more likely to persist. However, the problem of adjustment for both the long-term and the short-term patient is needful of action.

THE FUNCTION OF THE HALFWAY HOUSE

The halfway house can find a site for bridging the hospital/community gap within the area sketched above. It should seek to modify the patient role of the ex-hospital inmate and help him to build a normal social role. It should provide him with new models for identification. It should also provide a place where the patient can demonstrate to the community and to himself his effectiveness as a normal social organism, while offering him some protection from the stresses of a more rapid integration with that community.

The achievement of these goals has implications in the staffing, location, selection and size of population for these institutions, and in their activities. Particularly, selection should not be based on conven-

tional psychiatric criteria. Rather, the concern should be directed to select patients who have become overidentified in the patient role and/or those whose immediate social environment contains attitudes not conducive to reintegration.

In order to build an integrated social role the expatient has to learn to conform to socially acceptable patterns of behavior. Since the patient is to return to the community the sanctions against such behavior must be expressed in community terms but without disruptive hostility. One author at least (1) has found that "authoritarian attitudes of houseparents may serve to stimulate corrective emotional experiences in the greater freedom of the rehabilitative house environment."

Also, the patient must be helped to relinquish the patient role by reducing the props that support it. As has been indicated, these props are to be found in part in the trained attitudes of many psychiatric personnel, and such people may not be the most appropriate to staff halfway houses, as is so often believed. (It may not be enough merely to separate hospital nurses from their uniforms.) Other supports are to be found in the large hierarchical organization of the hospital. To combat this and to produce a social organization more related to community living, the halfway houses should be small. Also, the houses should be removed from proximity to mental hospitals and placed more firmly in a community setting.

One of the greatest supports for the patient role is its reinforcement by interaction with other patients. If, however, this group is small and the individual is forced to make contact with normal social groups and normal social functions in work and leisure activities, this has some combative force. It is often very striking to

hear house residents, following acquisition of some normal social identification, complain increasingly of the behavior of their house colleagues, and thus demonstrate their increasing distance from identification with that group. Some attempts have been made to hasten normal identification by having nonpatients as part of the resident halfway house community. This has been attempted in Boston (8), where psychiatrically untrained university students live together with chronic psychiatric patients in a house setting, although this may not be the most appropriate identification group.

As the halfway house resident learns to work in the community and gradually acquires a normal social role, he is providing not only reassurances to himself but also a feedback to the community (and particularly to his family), which demonstrates his effectiveness and paves the way for his reintegration.

CONCLUSION

A brief framework has been developed toward the formulation of a model for the function of the psychiatric halfway house, within the context of the current psychiatric scene. While mental hospitals are moving rapidly from the concept of institutional care toward the concept of a therapeutic community, and vigorous efforts are being made to keep and treat the potential hospital patient in the community (3), there remain many gaps in a complete understanding of hospital and community processes. By attempting to resolve the problems of role-taking and community perception, the halfway house may contribute something to this understanding and indeed narrow the gap between the hospital and the community.

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A history of challenges in child psychiatry training

The child guidance movement in this country, from which child psychiatry evolved, began in the 1900's under the influence of men like William Healy. He started the first child guidance clinic in the United States at the Juvenile Psychopathic Institute in Chicago in 1909 to study and treat juvenile delinquency (7).

Somewhat earlier, about 1906, Lightner Witmer, a psychologist, opened the first psychological clinic in Philadelphia (6). His memorable papers were the first to attempt to differentiate mental retardation from psychoses of childhood and to describe efforts at treatment and came from his experiences there.

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Herman Adler, Karl Menninger, David Levy, George Stevenson, Sheldon Glueck, Lawson Lowrey and others began the American Orthopsychiatric Association in 1924 (3). Several years later Fred Allen began his pioneering work at the Philadelphia Child Guidance Clinic. Adolf Meyer, in conjunction with the Department of Pediatrics at Johns Hopkins, established the first child psychiatry service under Leo Kanner in 1930. The first official use of the term "child psychiatry" in the United States was in Kanner's *Textbook of Child Psychiatry* published in 1935 (1).

The National Committee for Mental Hygiene through its Division of Community Clinics, directed by George S. Stevenson, used Commonwealth Fund and Rockefeller Foundation funds in the late twenties, thirties and forties to begin to finance demonstration clinics, to provide stipends for training child psychiatrists and to help communities and medical centers to establish child guidance clinics.

In the late 1920's and early 1930's Ameri-

can psychiatrists interested in work with children sought training with Anna Freud and August Aichhorn in Vienna. With Hitler's rise to power many Austrian and German child analysts came to the United States and began to consult in the burgeoning child guidance clinics of the day. At the same time, Adolf Meyer encouraged the study of the effect on the child's troubles on all aspects of his living, physical, neurological, psychological, as well as family and cultural influences (1). Thus, in the late 1930's and early 1940's, the fusion began of Freud's psychoanalytic theory, as applied to diagnosis and treatment, and the study of the whole child and family under Meyer's influence, which eventually resulted in the classical American child guidance approach.

From the very beginning, the need for child psychiatrists was great. Even today, some 40 years later, there are 12,000 members of the American Psychiatric Association and only a handful—some 250—trained child psychiatrists and some 2,500 psychiatrists who are interested in and report that they do some work with children.

It became clear, long before the 1930's, that the child psychiatry trainee, in order to fulfill his function in diagnosis, treatment and community relations, must acquire skill in psychotherapeutic work with children and in collaborative work with his usual coworkers. The psychiatric social worker, in addition to her traditional jobs of intake and community agency relations, usually did some work with parents. The clinical psychologist, whose primary responsibility was psychological testing of children, also worked psychotherapeutically with family members. The work of Glueck, Healy and Bronner, which emphasized the increased need to understand family problems and sociocultural factors in juvenile delinquency, influenced child psychiatrists

to become increasingly concerned with the entire family in understanding the variety of children's problems and in trying to ameliorate them.

More psychiatrists began themselves to see parents and to work with them as well as with the child in the playroom. Very early, such child psychiatrists studied the somatic contributions to the child's emotional disorder, such as brain damage, mental defect and the sequelae of encephalitis.

The clinical team, under psychiatric direction, anticipated today's concern with community mental health and consultation as they consulted and conferred with schools, courts, other child serving agencies, especially foster home placement agencies, about evaluation and treatment of children (2).

Starting in the 1920's with New York City's Bellevue Hospital, which has been under Loretta Bender's direction since 1935, inpatient units for the study and treatment of children, preadolescents, and adolescents with psychoses of childhood and those organic conditions which posed diagnostic problems, spread throughout the country in the late thirties and forties (1).

Out of such experiences child psychiatrists began to delineate a field separate from and yet intimately related to general psychiatry. This awareness was expressed shortly after World War II when, in 1948, a committee of the American Psychiatric Association Section on Child Psychiatry recommended to the Council that it consider recognizing child psychiatry as a distinct subspecialty. In 1948, also, the American Association of Psychiatric Clinics for Children was born. It helped to elaborate and further clinic and training standards in child psychiatry. In 1953 the American Academy of Child Psychiatry was formed to provide a meeting ground for

those concerned with training and research in child psychiatry.

Finally, in 1958 the Council of the American Psychiatric Association accepted the recommendation of its Committee on Child Psychiatry that child psychiatry be recognized as a separate subspecialty requiring special training. In 1959 child psychiatry became the first subspecialty under the American Board of Psychiatry and Neurology. Examination for certification in child psychiatry requires prior certification in adult psychiatry, at least two years of approved general psychiatry training and two years of approved training in child psychiatry (4).

During all this period, from the early 1920's to the present, the challenge has always been to produce more child psychiatrists who can service the needs of the nation's children more effectively.

Recent conferences on training in child psychiatry resulted in part from the concerns of those involved with training to examine and establish some hierarchy among the many and varied aspects of training considered by some as vital to development of the complete child psychiatrist. Some of these areas are as follows:

- (1) Courses and supervised training in supervision of psychiatrists and other clinic personnel.
- (2) Training in infant development and observation of the nursery school child as well as work at primary prevention in prenatal clinics and of secondary prevention in well-baby clinics.
- (3) Training in group therapy with both children and parents.
- (4) Training in drug therapies and other somatic therapies.
- (5) Training in consultative methods with pediatricians and other medical specialists.
- (6) Work with inpatient children and

training in intensive psychotherapy with psychotic children.

- (7) More intensive work with courts and juvenile probation departments as well as with sociologists in evolving preventive and treatment methods in juvenile delinquency.
- (8) A period of work in school systems to learn to be helpful to teachers and to begin preventive work in kindergarten and the primary grades.
- (9) Each trainee must have experience in treating every variety of childhood disorder.
- (10) Greater emphasis on treatment and research in psychosomatic disorders.
- (11) Seminars and practice in administrative psychiatry, especially in working with lay boards of directors and in administering large institutions for children.
- (12) Work with traveling clinics and state hospitals where there are no child psychiatrists.
- (13) Community psychiatry and mental health consultation to all child serving agencies.
- (14) Greater emphasis on training and research in mental deficiency.
- (15) Training in research methodology and an opportunity to do a well-supervised research project.
- (16) Training in scientific writing, and more.

All of these areas we feel are important and express the scope of the need for trained personnel. Many other centers whose programs are familiar to us as well as our own program do attempt to provide some training in many of these aspects. How all of these skills can be well learned in a two-year fellowship in child psychiatry is our concern.

However, our experience suggests that there are core skills of the child psychiatrist which permit him to learn to work in whichever of these he selects. Many of us feel from experience that these skills stem

from a thorough grounding in individual psychotherapy (5).

In other words, it may be difficult for the trainee to learn the methods in these fields, to meet the exciting current challenges in primary prevention, in new treatment methods, in community psychiatry and in work with lay groups, etc., without the previous experience in individual therapeutic work. Such experience helps him to understand:

- (1) That most human troubles come from internalized conflicts which make it difficult for people to find rational solutions for their difficulties.
- (2) That children's difficulties which result from living with troubled parents are not visited on them with malice aforethought but stem from the parent's own troubles and difficulties in finding satisfactions for themselves.
- (3) That, in some instances, it may take a long time to modify severe disturbances encountered in individuals.
- (4) That educative methods have a better chance of helping people if one also understands what the internal conflicts are that make it difficult for people to make use of these methods.
- (5) That any brief psychotherapeutic work or emergency psychotherapy may be more effective if one's judgment is based on a background of therapeutic experience and understanding from intensive, prolonged, individual work. One then knows that acute crises occur in a matrix of previous difficulties and the most relevant help comes from learning to understand how and why the whole personality is reacting to acute problems in this way.

It is in this light that I present a few illustrations of how the psychotherapeutically trained child psychiatrist might function at the forefronts of today's challenging problems of community work,

work with mentally retarded children and their families, mental health consultation and primary, secondary and tertiary prevention.

I. Education of Lay Groups

Frequently child psychiatrists are asked to help educate such lay groups as P.T.A.'s. We have found that the trainee best understands parent-child relations as a result of his psychotherapeutic work with them, where he has learned not to blame parents for the child's ills but to recognize the unwitting effect of their difficulties on the child. A child psychiatrist so trained tends to talk about children's problems to the lay public with an eye toward helping the parents understand the kinds of attitudes which help the child grow emotionally so he can learn to cope with life's problems.

He also recognizes with the parents why such attitudes are sometimes difficult to achieve. Out of his therapeutic experience he knows that to give pat prescriptions which no troubled parent can follow because of his own emotional involvement with the child and the other parent, may only aggravate the situations. His emphasis is therefore on making evident his understanding and empathy with the parent's concern and discussing possible reasons for the child's behavior which may be modified by particular parental attitudes.

II. Work with the Mentally Retarded

The frequent and heartrending experience of the mentally defective child's parents' unceasing search for a magical cure for their child is familiar to most child psychiatric facilities and to many of you in other professional fields in the audience. Why do these parents fail to heed the professional advice about the

nature of the disorder, its course and the possible eventual need for custodial care?

Too often we hear from these parents that they have been told by experts that their child is hopelessly defective and that they have been advised or even admonished to place the child immediately in a custodial institution. There are data showing that only about 10 per cent of such children are untrainable and uneducable for various reasons. The psychotherapeutically trained child psychiatrist, on seeing such a family representing the remaining 90 per cent, immediately becomes concerned with understanding the parents' particular relationship with the retarded child in terms of their background, other children in the family, their current life status and their satisfactions and what their hopes had been with this child. In addition, their assessment of the child is not only in terms of its mental defect but of its emotional state.

The endeavor is to understand to what degree and how the child has reacted to his parents' concerns and wishes for him so that he is unable to function to the fullest of his retarded potential. Often a destructive, aggressive, hyperactive, retarded youngster can be helped by psychotherapeutic work with child and parents so that he can live more peacefully and productively at home, with parents who can accept more easily his limitations and enjoy the satisfactions which come from his daily pleasure and unstinting affection and their less guilty satisfactions from other areas of living.

III. *Primary Prevention*

In yet another area, that of primary and secondary prevention, only the child psychiatrist who is well-trained in psychotherapy with children and parents can recognize the beginnings of a disorder in

an infant and young child, not only from its behavior, but also from the mother's attitudes towards the infant. Further, only such thorough training helps the psychiatrists understand why the parent behaves toward the child in such a way and how the mother may be helped, through brief emergency psychotherapeutic contacts to behave differently with her small child.

A case in point.

A mother came to a public health well-baby clinic with her five-month old infant. The infant's "good," i.e., placid, uncomplaining behavior had occasioned many favorable comments from the nurses. On this occasion the child psychiatrist was in the center, and on hearing these comments looked at the infant, who appeared flaccid, immobile, withdrawn, nonsmiling, lethargic and with no interest in its surroundings.

A brief observation of the mother and infant showed that mother seemed unable to cuddle the baby and held the child stiffly away from her. A few words with mother led to the history of a baby left to itself all day except for requisite bottles propped in bed and a few diaper changes. Mother, too, commented about what a good uncomplaining baby she was. Further inquiries revealed that this was a first and unwanted child for this recently married, impoverished young couple. Mother, in response to sympathetic understanding of her feelings, was able to express both her resentment of the infant and its curtailment of her fun and her fear of handling her lest she hurt her. With some further exploration of her feelings and some encouragement to hold the baby at least for feedings, the mother left.

Over the next four months, monthly brief interviews with mother helped her with her feelings about herself and her child so that she could begin to cuddle, play and enjoy it. By one year of age this was a bright-eyed, curious, active child who was trying to talk, a far cry from the depressed, schizoid infant at age five months.

IV. *Community Psychiatry*

Let me end these illustrations with one which demonstrates the application of

firm grounding in psychotherapy to the consultation process and community relations. A grammar school principal called in the psychiatric consultant, a child psychiatrist, with some reluctance because of previous experiences with a psychiatrist who antagonized his teachers by telling them what was psychologically wrong with them. However, his teacher was having such a desperate problem with a youngster in her class that the administrator decided to try again with the new consultant.

This consultant heard out the teacher's severe problems in controlling an aggressive, hostile, demanding, exhibitionistic 11-year-old boy who kept the class in a constant turmoil. From the teacher's historical account of the boy, he'd been only a minor problem with a male teacher the year before. Further exploration with the teacher revealed her strong preference for the well-motivated, well-behaved child who wanted to learn. She seemed unable to understand any other child, and thus she felt anxiety and impotent anger toward children who were hyperactive, aggressive, demanding of her time and not interested in learning. As he had learned to do in understanding family problems, the consultant began to speculate to himself about the circular impasse such a teacher and child would find themselves in and began to speculate aloud from his experience with children what this youngster's behavior might be saying in a disguised way.

As the teacher began to see that the hyperactive behavior might indicate the boy's great need for personal attention and concern in his struggle to begin to learn, (since he'd mastered few of the basic skills), the teacher began to talk about how she might help him learn and by what means, etc. The consultant also sensed her anxiety about the expression of her own angry, hostile feelings when, highlighted

by this child's violent behavior, again there was a parallel to situations between parents and children. He recognized that her feelings might make it difficult for her to be firm with the boy, and he encouraged her to both offer help and to set limits for the boy as a means of helping him feel more cared about and secure.

After four such meetings with the teacher there was a marked shift in the attitudes of both the child and the teacher. There were other effects of the consultation as in diverse ways the child psychiatrist's help in this troublesome problem encouraged other efforts to work with the aggressive, hyperactive child first in this school and later in other community agencies.

In conclusion I would like to emphasize, first, that most training centers are acutely aware of the community's needs for more child psychiatrists with more specialized training. In concert with other training centers, we on the senior faculty of the Children's Service of the Langley Porter Neuropsychiatric Institute are constantly presented with the need to assess and divide our time between the pressing needs of severely ill children and their grievously disturbed parents, training programs for other disciplines, research and general community needs.

Despite the involvement of the senior staff with obligations to professional societies, national committees and conferences, we try to provide the kinds of fundamental training which our 16 years of experience has shown help to create teachers, team leaders, researchers in child psychiatry and dedicated community minded child psychiatrists.

By statute, as a part of Langley Porter Neuropsychiatric Institute, we are committed to research which, although long and painstaking, may further our knowl-

edge of childhood psychosis, mental deficiency, mental health consultation methods, psychosomatic disorders, etc. It may be of interest to this conference that 44 child psychiatrists have been trained since 1946, a few for one and most for two years on our service. All of them have given some time to community child guidance clinics and/or community agency work, teaching and consultation. Seventy-five per cent have given more than one-fourth of their time to such activities and almost half of our graduates have given more than half of their time to these activities.

To meet the current needs we are constantly endeavoring to refine our teaching methods and to experiment with new ways of training. Comparable statistics are available from other training centers. Although all of us train relatively few child psychiatrists, the overwhelming majority devote a large part of their time to aspects of community mental health.

I would like to emphasize, secondly, the responsibility of each community to utilize its trained personnel wisely. The great needs of a community for treatment services, consultative help to child-serving agencies, and preventive services need careful scrutiny and evaluation by lay leaders in terms of how the most urgent requirements may be met. An effort to select the areas of highest priority to focus on may help the trained mental health workers to do more effective jobs and may prevent the discouragement that so often comes from being overwhelmed with demands for service.

Often the community leaders' careful assessment of the tasks at hand will focus the energies of the professional personnel on consultative work with child-serving agencies, to help them do their own jobs more effectively with the milder disturb-

ances which usually require most of the help in any community. Our efforts in the forefront of mental health in the community must be joint ones.

SUMMARY

The challenges in child psychiatry training, beginning with William Healy in 1909, have always been to produce well-trained, competent child psychiatrists in ever-greater numbers. Under the influence of Adolf Meyer and Freud, child psychiatry became increasingly concerned with the understanding and treatment of the whole child, and later included work with parents.

In recent years, with emphasis on research, prevention, drug therapy, mental health consultation, and many many other important aspects of training for the complete child psychiatrist, there has been an increased tendency to fragment the training program.

This paper supports the point of view that only through thorough grounding in psychotherapy is the child psychiatrist prepared with the judgment and skill necessary for work at the forefronts of child psychiatry. Illustrations of how training in psychotherapy helps the trainee to work in prevention, mental retardation, work with lay groups and schools are presented.

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Contributions of a speech pathologist to the psychiatric examination of children

Psychiatrists and psychologists have long been interested in the speech and hearing skills of their patients, because the ability to talk distinctly and to understand what is said facilitates and enhances the patient's ability to express his feelings and make his needs known.

Therefore, it is strange that, in general, psychiatric and psychological reports and research deal with speech and hearing in only a summary fashion. While the task of going beyond a cursory evaluation of

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speech and hearing has had only passing interest for psychiatrists, speech pathologists have too often focused only on the mechanical aspects of speech and hearing. Thus, undue concern with the phonetic, physiological and neurological aspects of speech and hearing has often led speech pathologists to disregard psychological aspects of difficulties in verbal communication.

An awareness of the need for a more comprehensive and integrated study of a patient's speech and hearing led the Children's Division of The Menninger Clinic to invite a speech pathologist to participate as a member of the diagnostic team during outpatient evaluations. This paper describes the results of this experience in terms of the speech and hearing characteristics of children referred to one psychiatric clinic and how such findings can deepen, in an important way, the diagnostic understanding of children.

PREVIOUS RESEARCH ON SPEECH AND HEARING SKILLS OF PSYCHIATRIC PATIENTS

As a prelude to presenting the data gathered by the present investigators, a sampling will be offered of previous research in this area by psychiatrists, psychologists and speech pathologists. In general, psychiatric authors have used broad descriptive terms when they have discussed the speech and hearing skills of their patients. No published research was found on how psychiatric patients hear and understand spoken language.

Bleuler's 1924 *Textbook of Psychiatry* (4) discusses the speech characteristics in such general statements as "the vivid speech of the manic patient," "the baffling and stammering speech of the idiot," and so on. Although more space is devoted to verbal communication in such a recent publication (1959) as *The American Handbook of Psychiatry*, surprisingly little change has occurred in the manner in which speech is described.

Thus, for example, Spiegel (13) in talking about verbal communication in depression states: "In agitated depression, the voice may be rasping and low pitched, but articulation is brisk and fairly rapid, tense, with considerable range of pitch." Later in the same article she writes: "In the hypomanic state, typically, articulation is vigorous, sometimes with self-aware eloquence." Thus, Spiegel, along with others in this handbook, presents descriptions of speech so broad that they prevent any detailed analysis of possible meanings.

However, not only reports of individual cases but also statistical studies of large groups are couched in broad terms. For example, Page and Page (9) in 1941 reported, after analyzing the clinical records of 500 consecutive admissions to a New York State hospital, that 56.4 per cent of

this group manifested speech abnormalities. The precise nature of these abnormalities was not specified, so that any inference as to their possible meaning was precluded.

In a notable exception to this trend, Weiss (15), although wary about making any generalizations about speech disorders among the psychiatric population, felt "that certain categories like the catatonic and hebephrenic schizophrenics show a greater frequency of dyslalic deviations than their paranoid counterparts."

Recently, speech pathologists have begun to publish incidence studies and descriptions of the speech of certain psychiatric populations. Of 1,822 patients in an Indiana hospital, who were examined by Green (6) and her coworkers, only 221 demonstrated adequate articulatory skill. The chronological age of her subjects was such that theoretically they all should have had normal speech. She also reported that defects in voice quality were present. Further important findings of her study were that the more severe the functional or organic involvement, the more severe the articulation problem. Furthermore, articulation difficulties tended to become more accentuated with prolonged hospitalization and increasing age. No report was made of any attempts to integrate her observations into the psychiatric diagnostic understanding of the patients.

A study by Grimes (7) of the speech and language characteristics of eight children in outpatient psychiatric treatment revealed that the articulation abilities of her group were below the level of a group of normal children. As in Green's study, no attempt was made to fit the speech disturbances into any broader psychiatric context.

Finally, it should be noted that many reports have equated the terms of speech

and language. This unfortunate fact has resulted in reports of speech evaluations being done on psychiatric patients, which were in reality studies of language functioning. As used in this report, speech is meant to refer to the sounds, or as they are technically termed, "phonemes," which when used together in certain accepted ways should then produce verbal language. Verbal language refers to the symbolic meanings attached to these sound groupings.

The foregoing data shows that psychiatric writers tend to discuss speech and hearing data so broadly that their significance is lost, and that speech pathologists report their observations of speech as though this were a separate entity from the individual patients' personality. Notable exceptions to these generalizations on the part of psychiatrists, psychologists and speech pathologists are found in the works of Barbara (2), Murphy (8), Sheehan (11) and Travis (14), who have conceived of speech as an integral part of total personality functioning.

The failure to translate the speech and hearing data into specific terms which could be integrated within the total psychiatric understanding of a child is partly related to the lack of understanding of the assumptions and techniques which each area holds to be important. As an initial step in overcoming this deficit, as well as to introduce the findings of this study, the next section of this paper will present some of the assumptions and techniques utilized by the speech pathologist who participated in this study.

THE ASSUMPTIONS AND TECHNIQUES OF THE SPEECH PATHOLOGIST

Basic to the understanding of the operation of a speech pathologist is a conceptualization of what a speech disorder is. The

normal use of colloquialisms or regional dialects are never thought of as manifestations of disturbed speech. Likewise, the normal developmental errors made by children during their first seven to eight years of life are never considered as speech defects. Excluding these variations in speech, speech becomes defective when a person cannot adequately and smoothly convey his thoughts to his own or to others' satisfaction. This may be due to anatomical or neurological inadequacies of the speech apparatus, or may be symptomatic of underlying unconscious or interpersonal conflicts. Sometimes defects in speech occur of which a person is unaware; sometimes he is aware of his difficulties; sometimes the environment in which he lives recognizes his difficulties in verbal communication. Not infrequently a definite speech anomaly of which the individual and his peers are unaware is detected by the speech pathologist.

With this definition in mind, we next turn to a broad discussion of how speech pathologists describe the anomalies of speech. Articulation of sounds is described by the speech pathologist on the basis of (1) whether there is an omission of the sound in question; as, for example, the child who says "mo-er" instead of "mother;" (2) whether another sound is substituted for the one expected, as when the child says "wed" instead of "red;" and (3) whether the sound which is articulated is so distorted that it is impossible to describe accurately what has been said. In doing this, speech pathologists make use of a series of symbols known as the International Phonetic Alphabet. The advantage of this system is that it allows one to describe accurately the sound in question without using a tape recording or resorting to letters of the alphabet.

In addition to the description of sounds

noted above, certain classes of articulation errors have specific names. For example, substitution of the sound "θ" (a voiceless "th" as in "thanks") or a "ð" (a voiced "th" as in "them") for the sound "s" as in the word "cement" or "suit" is called a lisp.

There are different kinds of lispings which can be specified; e.g., frontal and lateral lispings. Lipping tends to occur more in adult females than males and often occurs in individuals who want to remain immature and not grow up. Another class of articulation errors is dysarthria. The term dysarthria connotes to speech pathologists articulation problems resulting from neurological impairment of the speech articulators. Unfortunately this term is indiscriminately used to signify speech disorders having both psychogenic and neurological etiology.

Another group of deviations studied by speech pathologists includes disturbances in phonation. Detection of abnormal phonation is difficult in many respects for the usual observer. Society in general tolerates wide variations in the usual dimensions of phonation; viz., pitch, loudness and quality. It is precisely because the voice quality is indeed so flexible that it offers fascinating possibilities for study during a diagnostic evaluation. Apart from the normal pubertal change of voice, any deviation or change from the normal voice may be symptomatic of organic or psychological malfunctioning.

A final broad group of speech disorders which speech pathologists look for includes disturbances in the rhythm of speech. The largest subgroup of this category is called stuttering. This is probably the most poorly understood of the commonly occurring speech disorders. Ignoring a considerable body of evidence suggesting that stuttering is a multiply-determined difficulty, too many professional people continue to

look for just one etiological factor. This is probably the main reason why various therapeutic approaches up till now have proved to be so disappointing and ineffective.

The verbal behavior we call stuttering may be not only a symptom of complex underlying emotional conflicts, but also evidence of bona fide neurological difficulty. The communication difficulty often varies not only from patient to patient, but is variable in the same patient from time to time. The speech pathologist can study the exact nature of such difficulties and his observations can give leads to possible underlying etiological factors, thus making a more rational and comprehensive therapeutic intervention possible.

The other major category included under the heading of disordered rhythm in speech is called tachyphemia. Arnold (1) has outlined the main characteristics of the speech and voice in tachyphemia. The voice is monotonous, with notable breaks in phonation. There is a hurried, hasty and increased rate in speech. The rhythm of speech is jerky, stumbling and explosive. In contrast to the awareness and concern about speech typical of individuals who stutter, there is an unawareness and unconcern by the person of the imperfection of speech patterns typical of tachyphemia.

Another facet of any speech evaluation is the study of the physiological adequacy of the speech mechanism. It needs to be noted that the actual contribution of the tongue, teeth and lips to intelligible speech is usually overemphasized. For example, adequate speech can be produced with a minimum of tongue flexibility.

In addition to the aforementioned structures, the speech pathologist notes the adequacy of velopharyngeal closure. Inadequate movement of the soft palate can produce a nasal voice. A congenitally short

palate may also produce similar problems. One method of evaluating adequacy of palatal movements is to make X-ray studies of the velopharyngeal closure which is present during phonation of vowels. The adequacy of the rapidity of movement of the speech articulators is studied by establishing the diadochokinetic rates. This is done by counting the number of times a child can approximate the speech articulators together in a given amount of time. Poor diadochokinetic rates are suggestive of neuromuscular inco-ordination.

A last aspect of the speech evaluation is the study of the child's hearing. Hearing laboratories with special acoustically treated rooms are needed for accurate assessment. Children unable to co-operate with standardized procedures often can be evaluated by behavioral observation. However, given the proper orientation, the majority of children referred for a psychiatric evaluation can have their hearing sensitivity assessed by either standard audiometric procedures, or by the use of procedures utilizing either electroencephalography or the psychogalvanic skin response.

THE FINDINGS AND CONTRIBUTION OF THE SPEECH PATHOLOGIST TO THE PSYCHIATRIC EVALUATION OF CHILDREN

To demonstrate the extent of speech and hearing problems in a group of children referred for outpatient psychiatric evaluation as well as to show the contributions a speech pathologist could make to the total diagnostic picture, it was decided to conduct 30 consecutive speech and hearing evaluations at the outpatient department of the Children's Division at the Menninger Clinic.

The typical cases seen had been evaluated by several clinics prior to their present evaluation and were on the whole seriously

disturbed. The psychiatric evaluation of each child lasted five days. The psychiatric diagnoses given these children were as follows: Eleven children had disturbances associated with organic processes. One child was diagnosed as "a behavior disorder of childhood." Three children were diagnosed as "character disorders," seven as "psychoneurotic" and eight as "psychotic."

An initially startling discovery was the extent to which speech was disturbed. In all, 25 of the 30 children, or slightly more than 83 per cent, exhibited maladaptive patterns of verbal communication. That such a high incidence was found emphasizes not only the extent of disordered verbal communication among psychiatric patients, but also underlines the necessity for the psychiatric team to consider this aspect of behavior in their total diagnostic impression.

In 23 of the 25 children with speech difficulties, definite disorders of articulation could be observed. Utilizing the three basic dimensions of articulatory pathology; viz., sound omission, sound substitution and sound distortion, it is possible to make some summary statements. Sound omissions were observed primarily in children who were significantly retarded. Sound substitutions could be observed in children with a wide variety of difficulties, and sound distortions occurred in children with congenital choreiform movements or among those whose anxiety level was high. Although this sample is too small to offer adequate proof, it did appear possible that certain sound difficulties occurred more frequently in certain psychiatric disturbances than in others. If this proves to be the case in further research, a study of the origin, nature and economic dynamic meaning of the sound difficulty may well deepen our understanding of these disturbances and will augment our diagnostic acumen.

How a definitive study of articulatory ability and the factors which influence it contributes to the total diagnostic picture is illustrated by the case of a five-year, ten-month-old boy referred because of poor response to past psychotherapy. Part of the task to which the psychiatric team directed its attention was trying to define the relative roles of a severe emotional disturbance of autistic proportions and of mental retardation, both of which had been said to be present in the child in diagnostic studies done elsewhere.

Psychological examinations conducted by the psychiatrist and psychologist emphasized the likelihood that the boy was basically a severely defective, organically damaged child. However, sufficient doubt remained because of the child's age so that the psychiatrist and psychologist hesitated to commit themselves to a final diagnosis. Observation of his speech sounds suggested that he used sounds with no greater facility than that of a child at or below one year of age. At this level, his sounds were used to promote relationships and to establish contact with people in his environment. He gave clear evidences of responding to sound in the primitive fashion expected of a child around one and one-half years of age. His voice quality was not suggestive of a deaf child. There were no evidences of significant neuromuscular involvement of the speech articulators.

These findings supported the psychiatrist's and the psychologist's impressions of severe mental deficiency as the basic disturbance. This finding made it possible for the team to make recommendations to the parents with much more conviction.

Among the 25 children with speech difficulties in our sample, eight displayed a tense, hoarse voice. Seven of these children had been severely deprived of parental love in their early lives. They had not devel-

oped adequate object relationships and showed an unusual amount of frustration with many angry outbursts. Thus, the tense manner of phonation may be evidence of deep underlying frustration and anger and may be a significant symptom to follow. In none of these cases was the hoarse voice a primary or even a secondary complaint of the parents.

In the sequence of consecutive evaluations, no instances of stuttering or disorders of speech related to such organic conditions as cerebral palsy or cleft palate were noted. Only seven of the children with speech disorders had had any previous speech therapy. It is of further interest to note that, following our evaluation, only 16 of the 25 children with defective speech were recommended for speech therapy during or following psychiatric treatment. No recommendation for speech therapy as the only therapeutic or remedial measure among this sample was made.

Since not all of the children sustaining a speech disorder were recommended for speech therapy, it may be of interest to discuss briefly the criteria we used for recommending or not recommending speech therapy as part of the total treatment program planned for the child. The questions we asked ourselves in deciding the proper recommendation were as follows: (1) Is the speech difficulty always present? (2) Is the speech difficulty related to a meaningful clinical entity which is likely to change as progress occurs in psychotherapy? (3) Does the speech difficulty assume a degree of autonomy which seems independent of the psychiatric problems? (4) Would the speech difficulty interfere with the communication necessary for psychotherapeutic progress? (5) Would continuation of the speech difficulty pose a threat to the patient's speech mechanism?

In the nine children for whom no speech

therapy was recommended, the speech difficulty very clearly was an integral symptom and direct expression of the underlying emotional disturbance and conflicts. In these children the speech symptoms fluctuated. Indeed, in six of the nine children for whom no speech therapy was recommended, the speech difficulties showed up only periodically, and at times these could be predicted from the over-all dynamic understanding of the children's disturbances. What usually triggered these difficulties was a wish to conceal certain conflictual thoughts and feelings; but environmental or internal psychological duress could also bring out the speech disturbance. Of the remaining three children, one displayed a tense and mildly nasal voice which clearly fluctuated with his emotional state; another lisped inconsistently and primarily only when discussing emotionally-laden topics; the third child sustained an inconsistent substitution of the sound "w" for the sound "r."

The evaluation by the speech pathologist may also clarify aspects of the child's emotional environment which are related to speech and language. This aspect is especially important in nonspeaking children. A technique for study of their attempts at communication within the family group is used wherein the child and parents are observed through a one-way vision mirror. An excerpt from a report on one such observation of a five-year, ten-month-old girl and her parents illustrates the type of information obtainable.

"One might characterize this girl's speech environment as one where there is a hailstorm of adult command, counter-command, and negative remarks, which are abated only by the parents' necessity to catch their breath. In this short time, the child is supposed to contribute a 'yes' or 'no', but nothing more. If this is the usual speech environment,

it certainly is a situation which would almost totally inhibit spontaneous formulation of language, encourage rejection of sound and make it necessary for her to use what speech and language she has in a defensive manner. Her periods of unintelligibility then can be understood as regressions in communication under stress."

This vignette proved to be an accurate representation not only of the child's speech and language behavior, but also gave an accurate picture of parental interaction, as confirmed by the caseworker's notes and observations. One of the complaints of these parents was that their daughter was negativistic and tried to manipulate people by her actions, as opposed to her speech. This complaint fits in strikingly with the observations made by the speech pathologist that the child was not allowed verbal expression. This same observation could also explain why the child scored much higher on performance items in the psychological tests than in the verbal subtests.

Along with the study of a child's present speech environment, the speech pathologist also studies the conditions surrounding early speech development as they are reflected in the case history and the present functioning. The following example illustrates the information which becomes available.

The child was a two-year, nine-month-old girl referred for a psychiatric evaluation because of a lack of speech development and a concomitant concern by her parents over her aggressiveness and destructive tendencies. The speech evaluation disclosed that she did not use either speech sounds or language in interpersonal relationships. Interestingly enough, in this case both mother and father had largely ignored her, by virtue of illness on the

part of the mother and pressures of college work on the part of the father. The parents have continued to be unable to respond to this girl. They see her as being difficult to manage and less appealing than their other daughter.

All the members of the evaluating team, including the speech pathologist, however, found the girl to be quite co-operative and charming. In addition to the difficulties of the parents in relating themselves to this child, the speech pathologist noted signs of impaired tongue movements. While this undoubtedly contributed to part of her speech difficulties, it was not felt to be important enough to form a basis for a total explanation of the observed disturbance. Further, the neurologist found no evidence of significant neurological disturbance. Finally, the psychologist could detect no symbolic disturbance and felt her to be functioning somewhere between the two to two-and-one-half-year level from an intellectual standpoint.

Language used by the child, even though composed mainly of vowels, was similar to that seen in a child of between two and three years of age. This observation by the speech pathologist further corroborated the psychologist's conclusions. Utilizing this information, the psychiatrist and social worker tried to organize a program of rehabilitation which would focus not only on the child's speech difficulties, but also on the parent-child interaction.

The speech evaluation can make other contributions to the psychiatric evaluation. For example, a description of a patient's use of sound may allow one to arrive at an estimate of regression in his use of speech. Normative data are available on the use of vowels and consonants by infants through the thirtieth month of life, as well as from age three to age eight. By the thirtieth month of life, the relative per-

centage of the use of the various sounds in the English language approaches that of the adult.

An analysis of relative use of vowels and consonants was done for two of the severely disturbed children included in this sample. A profile of their use of speech sounds was obtained which suggested either a regression in the use of speech sounds or perhaps a failure to develop this aspect of communication from the beginning.

The idea of using speech data as an indicator of regression has been used by other investigators who, independent of the present writers and prior to the development of the idea in the present setting, also utilized this approach or at least suggested it. Shervanian (12) studied a group of psychotic children in this manner and Weiss (15), in reporting on logopedic operations in a mental hospital, also made this suggestion. Pronovost (10) has emphasized the same possibility in his study of the speech behavior of a group of autistic children. The close association between early development and speech and language patterns has also been emphasized by Bender (3) and Eisenberg and Kan-ner (5).

Another aspect of speech which was noted in this sample was that 13 of the children were reported as being late in their development of speech (the parents really meant language). Many other children's parents could not remember any details about this aspect of development.

This finding emphasizes that one symptom of distorted development is a delay in the acquiring of useful language. This delay in turn interferes with the child's further development as meaningful language based on correct use of speech sounds becomes more and more essential for the child's intellectual, emotional and social growth after about the fifteenth month of

life. In children who do not develop speech and language normally, the need is thus underscored for early referral for a comprehensive psychiatric examination, including a thorough neurological and a speech and hearing examination.

Physiological inadequacy was considered a contributory cause of speech difficulty in only four of the 25 children with speech problems. Even in these four cases the psychological factors were so important that the physiological factors could not be considered as the only cause of the speech difficulty. In none of the cases was tongue-tie noted, although some of the parents reported that they had had their child's frenum clipped in the hope that his speech would develop more adequately.

Although only 21 of the children were able to perform the necessary actions for testing diadochokinetic rates, some interesting trends developed. Agreement between normal and abnormal diadochokinetic movement and normal and abnormal findings of the neurologist was present in 15 of the 21 children tested. Where disagreements were found, a certain pattern was present. Thus, in five of the six children where normal diadochokinetic rates were reported, the only positive neurological finding was an abnormal EEG. In the remaining case the child had von Recklinghausen's disease.

A final area of data obtained on these children dealt with their auditory sensitivity and ability to make judgments about the relationships of incoming language. Three of the 30 children showed some auditory deviation, as measured by pure tone testing. One child manifested a genuine conductive loss; another demonstrated an abnormal tone decay. After this child had been in psychotherapy for three months, he was retested and the tone decay had disappeared. A third child manifested

a hysterical loss. The psychiatrist had noted other hysterical features in her personality and routine audiometric testing by the speech pathologist detected an inconsistent audiogram suggestive of a hysterical loss. The psychiatric understanding of the child was thus further confirmed as a result of the speech pathologist's evaluation.

Finally, a screening test of how well a child can differentiate as to sameness and difference of words was made. Among children who were capable of carrying out this test, 15 showed unusual difficulties. This magnitude made us feel that knowledge of how much difficulty a patient has in the differentiation of relatively innocuous speech and language might serve as a guide for future therapy in terms of altering the therapist as to the probability of deviant reception of any language he may use and especially any emotionally-charged verbal material.

We hope that in this brief presentation we have conveyed a picture of (1) the need for an intensive study of the speech and hearing of psychiatric patients; and (2) the important contribution the speech pathologist can make to an over-all psychiatric examination of children. Of course, we recognize that speech, language and hearing are only single aspects of a patient's emotional, intellectual and social behavior. However, disturbances in the former can seriously affect the latter, while disturbances in the latter can be traced or expressed in the former. Thus, a careful speech and hearing study can give many clues to the psychiatric team and can greatly deepen the understanding of an individual child's difficulties.

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Reactions of children during hospital admission: Three diaries

INTRODUCTION

Advances in pediatric medicine have led to concern about the importance of the psychological aspects of hospitalization. The effects of long-term hospitalization have been pointed out by Senn (6), while others (1, 2) have written of the general psychological and physiological effects of hospitalization.

Prugh, *et al.* (5), in a study of the emotional reactions of children to hospitalization, found observable reactions in all hospitalized children, but less severe reactions in children hospitalized in an experimental program designed to reduce the mal effects of hospitalization.

Most studies have emphasized "separation effects" in hospitalization, but few

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studies have concentrated on the actual procedures in hospitalization. By using interviews Erickson (3) and Gofman (4) gained knowledge about children's fantasies concerning various hospital procedures. Their interviews were conducted after the procedures had taken place.

This investigation was undertaken to determine some of the psychological meanings of admission procedures to the young child. Focus was upon the experience as perceived by the child himself. Since memory is often partial and fragmented, it was decided to observe the process of admission directly.

PROCEDURE

The study took place at a pediatric hospital. The hospital is "progressive" in the sense that it recognizes and attempts to handle the emotional needs of children during hospitalization.

Seven children below six years of age were followed through the usual admis-

sion procedure. Surgical and emergency admissions, which present special admission problems, were not used.

I followed the children until it was felt "admission" was completed. Notes were taken, and I attempted to remain separate from the ongoing procedures. I would usually introduce myself to the parent, briefly explaining that I was going to observe the admission in order to learn more about it. I was known to the hospital staff, who also knew I was "studying admission procedures."

REPORT OF CASES

Excerpts from three of the admissions will be presented in diary form. The notes are essentially the ones taken during the admissions. They undoubtedly contain "biases" and selective perceptions since I chose to record what I felt was important. Aware of my own biases, I attempted to record as objectively and disinterestedly as possible.¹

CASE NUMBER 1: JANE

Jane is a 4-year-old white female, admitted to the hospital for abdominal pains.

12:40 P.M. Jane and mother in lobby. (Jane looks frightened.) They do not speak.

12:45 P.M. Doctor B. arrives. Asks mother to bring child to examining room, adjoining lobby. Dr. B. asks Jane her age. Replies "four." He shows her "flashlight," simultaneously talking to mother. Mother describes symptoms. Dr. B. examines stomach, mouth and genitals. Dr. B. tells Jane to sit up.

12:55 P.M. Father sees me in doorway. Asks for Jane. I point into room. Dr. B. examines lungs. Jane sits quietly. Dr. F. enters. He examines her while talking with father. Jane stares at door as people pass. Some smile. She does not return smiles.

12:59 P.M. Mother puts pajamas on Jane.

1:01 P.M. Dr. B. tells parents that nurse will take them to ward. Mother hugs Jane. Father gets Jane's bunny. Dr. B. takes mother out to obtain medical history. He tells father to remain. (Father getting tense.)

1:05 P.M. Jane's local pediatrician, Dr. H., enters. Dr. H. examines Jane.

1:07 P.M. Nurse enters. Takes Jane's temperature rectally. Father says to Dr. H., "You'll let us know when you know something, won't you?" Dr. H. nods and leaves. (Father anxious.)

1:10 P.M. Student nurse enters. (Is obviously confused.) Weighs and measures Jane. Takes Jane and father to elevator. Carries Jane in her arms.

1:15 P.M. Arrives at ward. Nurse places Jane in crib. (Father very upset.) Father tells Jane not to suck thumb, not to jump around, etc.

1:25 P.M. Mother arrives with nurse and Dr. B. Nurse examines Jane, tells parents to stay, and leaves. Father asks nurses where children's bathroom is. Jane stares at bars on crib and begins to sob.

1:30 P.M. Parents talk to each other. (They smile in frozen manner.) Dr. B. and Dr. H. converse at doorway to room.

1:45 P.M. Parents leave. Tell Jane they will return soon.

1:50 P.M. Jane lying in crib. Looks up at me, says "Mommy," and starts sobbing. (She is losing control.)

1:55 P.M. Student nurse re-enters. Tells Jane to sit up. Crying continues. Nurse tells her to look at books. Jane does not. Nurse tells her to look at other children in room; tells her parents will be back soon. Jane sobs. Nurse (crossly) tells Jane to stop crying and leaves.

2:00 P.M. Crying dies down.

2:02 P.M. Lab technician enters with Dr. B. Dr. B. tells Jane to sit up. Swabs throat. Lab technician tells her he is going to make "red pencils." Pricks her with needle. She screams violently. He draws blood into tube as Jane watches. Pricks her ear, takes blood and leaves.

2:17 P.M. Jane lies in fetal position, sucking thumb and sobbing quietly.

2:40 P.M. Nurse enters. Jane does not look up. She lies and sucks thumb. Sobbing has ceased. (Is not responsive.)

CASE NUMBER 2: SUE

Sue is a 5½-year-old white female admitted to the hospital for frequent colds.

¹ Impressions, in contrast to actual observations, are in parentheses.

10:05 A.M. Sue and mother taken by Dr. W. into examining room. Joined by nurse. Sue wide-eyed.

10:10 A.M. Dr. W. examines Sue. He asks if okay to look in her ears. No response from Sue. Examines ears. Mother says that Sue was in local hospital for eight days. Dr. W. examines Sue's throat and back.

10:15 A.M. Father enters. Parents urge Sue to be "friendly." Dr. W. continues examination.

10:18 A.M. Dr. W. completes examination. Nurse asks, "how would you like to come upstairs?" (Father concerned about Sue not talking.) Nurse asks how Sue would like to wear blue pajamas. Sue cries. (Nurse anxious.) Nurse entices Sue up to ward. Parents tell Sue she must stay or she will have to come back later and stay for a "long time."

10:20 A.M. Sue quietly crying. Mother undresses her. Second nurse arrives. Weighs Sue. Father tells Sue to smile. Nurse picks up Sue. Tells parents to remain. Takes Sue to elevator.

10:35 A.M. On ward, nurse goes for tissues. Sue stands rigidly in middle of room. I offer her chair. No response. She has not yet spoken. Nurse returns. Nurse mentions that there is a hospital playroom where Sue can go. No response. Nurse takes her in hallway and introduces her to children. No response.

10:40 A.M. Sue walks around ward with nurse.

10:45 A.M. Nurse takes Sue to desk. They fix name band for her. Sue looks around (looking for me?) Nurse leaves. Sue stands in front of her room staring at people walking by. She neither moves nor speaks.

11:05 A.M. Sue's parents return. Nurse returns, leads Sue into her room and seats Sue next to mother.

11:12 A.M. Sue sitting with her parents. No talk. (She no longer looks bewildered.)

11:15 A.M. I leave ward.

Additional Note: At 1:30 P.M. I returned to the ward. Sue was standing at her door. She smiled, I spoke with her and she hesitantly responded. The nurses later informed me that she had previously spoken to them, but had not spoken to any male.

CASE NUMBER 3: TIM

Tim is a 23-month-old white male admitted to the hospital for gastrointestinal disturbances. He had had vomiting and diarrhea for two days prior to admission.

3:40 P.M. Mother and her sister, Tim's aunt, standing at desk with Tim. Mother's hand noticeably tremulous.

3:45 P.M. Dr. P. takes them to examining room. Tim sits quietly on examining table. Dr. P. lifts Tim. Tim whines. Mother says, "he's been waiting so long." Dr. P. examines him. He whines. (Both women attempt to comfort him.) Mother helps with examination. Tim kicks during examination. Refuses to open mouth.

3:50 P.M. Tim crying and kicking. Women offer bottle. He refuses. Mother holds him on lap. He calms down. Mother tells me she had been waiting for hours at another hospital but had been refused admission. (She appears desperate.)

3:55 P.M. Nurse enters. Tim screams. Dr. P. beckons mother out of room to obtain medical history. Nurse tells aunt to wait. Nurse wraps Tim in blanket. She carries him onto elevator.

3:59 P.M. Nurse places Tim in crib on ward. Struggles. Body rigid. Screaming. Nurse attempts to take temperature rectally. Struggles. Nurse moves him as she fixes crib.

4:03 P.M. Nurse removes blanket. Tim naked. She gives him bottle and leaves. She returns immediately and wipes his nose. Tim screams "mama." Nurse diapers him. He is calming down. Nurse puts up crib gate. He starts screaming. Screams for mother. Nurse leaves. Second nurse enters and speaks to him. No response. Nurse leaves and first nurse returns.

4:10 P.M. Nurse arranges equipment. Tim sighs. Nurse leaves. Tim screams. Nurse returns. Screaming ceases. Two new nurses enter. They tell him to be a "big boy" and not to cry. Nurse removes diaper and takes him in to be weighed. He screams. He is rigid. Alternately clings to nurse's neck and throws himself away from her. Tim weighed. When back in crib nurse takes temperature rectally. He does not struggle. Lies in fetal position and cries.

4:15 P.M. Dr. P. enters. Three nurses arrive and hold Tim down. Dr. P. attempts to draw blood from arm. Cannot find vein. Two attempts at insertion. Neither successful. (Tim in terror.) Nurses adjust him to attempt insertion in other arm. (He looks around desperately.) Tim alternately grits teeth and stiffens lips and neck. (Terror is extreme.)

4:20 P.M. Lab technician arrives. Tim held by three nurses. Technician pricks finger and draws blood. Lab technician leaves.

4:22 P.M. Dr. P. again attempts insertion of needle. Inserts needle into vein and draws

blood. Tim refuses band-aid. Screams. Nurse informs Dr. P. that Tim's mother is asking if she can see Tim before she leaves. Dr. P. shakes head.

4:25 P.M. Three nurses tape one of Tim's arms to board. Tie other arm to crib bars. Nurses tape fingers of hand and pin them to sheet. He is restrained tightly. At each subsequent adjustment he screams more loudly.

4:30 P.M. Piece of rubber tied on his arms. Three nurses hold him. Dr. P. attempts insertion of needle. Unsuccessful. Dr. P. continues attempts. Dr. P. sweating profusely. Tim screaming violently.

4:35 P.M. Dr. P. still trying. Tim alternately screaming and sobbing quietly. (Dazed look in eyes.)

4:40 P.M. Dr. P. still attempting insertion in vein. Tim shrieking less frequently.

4:45 P.M. (Everyone tense and upset.) Perspiration dripping from nurses holding Tim and from Dr. P.

4:50 P.M. Dr. P. inserts needle. Goes through necessary procedures. Tim breathing heavily. Stares. Mouth open and jaw slack.

4:55 P.M. Everyone leaves room. Tim alone. (Expression dazed.)

5:00 P.M. Tim in fetal position, thumb in mouth. He is quiet.

5:05 P.M. I leave ward.

DISCUSSION

Sue's admission appears fairly benign, Jane's somewhat traumatic, and Tim's intensely stressful. While each admission is different, they highlight several phenomena which I have observed to be true for many admissions.

The hospital staff is often faced with a number of difficult and conflicting tasks. They want the child to feel "comfortable" in his temporary home, they have examinations and procedures to complete, and they are confronted with one or more anxious parents. In addition, they have their own individual needs and goals to manage such as "doing a good job," handling their own fantasies and anxieties, etc. Little time, lack of space and insufficient number of personnel are difficulties which are present.

The physician's main desire is to complete his examination and obtain a history. The nursing staff wishes the child to be "happy" and to be no trouble, in order to free them for other tasks or for carrying out "procedures" on the child. Two goals seem to take precedence over others. The first is the physical well-being of the child, especially in serious illness. The second is the somewhat amorphous goal of "completing the admission procedure." (Physical examination, laboratory tests, obtaining a bed in the ward, getting into pajamas, etc.) Such goals as dealing with the anxiety of parents or not frightening the child are deemed expendable.

The child himself is faced with a multitude of new and strange experiences impinging upon him. Confusion is rampant; there is much new stimulation which he must face and, if possible, integrate. Many of these experiences are relatively "neutral;" e.g., new surroundings and strange people; but others, such as being undressed and handled, appear to be potentially terrifying. He confronts these events "by himself." In spite of the many people around the child seems to feel isolated and alone.

A striking phenomena is the constant lowering of the child's tolerance threshold. New and unintegrated experiences pile up. With each experience the child's threshold for control or for any kind of adequate response becomes lower. There seems to be no calm period in which he can rest and integrate the new and threatening experiences, until the point is reached when the threshold has been lowered below the control point. It is the intensity and accumulation of experiences which is important, rather than their specific nature.

As the threshold becomes lower, less intense stimulation is capable of causing further breakdown. Early in the admis-

sion procedure it may take severe pain to cause the child to loose control; later in admission it may be merely the appearance of a new and strange face.

Few strict rules can be laid down for admission procedures which, by their very nature, demand flexibility. The age of the child, the illness and the speed with which the procedures must be carried out are all contributing factors. Procedures necessary for the health and safety of the admission child are primary goals. Beyond this, however, admission procedures become a matter of choosing the more important within a vast array of goals. The child's comfort and emotional well-being should be of major importance. With this in mind, a number of suggestions can be drawn from the material.

The child should be recognized as a functioning individual who is confused and frightened. Things may have to be done to this individual but, if possible, his co-operation should be elicited. Such a goal implies that the hospital staff is not dishonest with a child, recognizes the child's right to be frightened, and does not deny the child the privilege of showing his fear. Attempts to make the child believe he is not fearful ("you're a big boy") serve little meaningful purpose.

The confusion circling about the child should be kept to a minimum. Procedures and examinations which can be delayed should be delayed.

Most important, one individual should be *in charge* of the admission procedure.

This is meant in a psychological rather than in an administrative sense. This individual could be a nurse, a social worker, or any warm and understanding person with appropriate training. She would be with the child constantly from beginning to end of admission and would consider and meet the child's needs. This person would be a stable and warm element for the child and would be aware of the mounting strain on him. She would also be sensitive to the falling tolerance level of the child and would act accordingly. Lastly, she would continue to be the child's friend and protector throughout the hospitalization.

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Discovering and meeting the mental health needs of emotionally disturbed elementary school children: With emphasis on children whose parents are inadequate

We have viewed with concern the inability of many social agencies to meet the mental health needs of seriously disturbed elementary-school-age children from deprived and disorganized home environments, or from character-disordered families.

Mental health agencies, family counseling centers and child guidance clinics appear primarily geared to serve the needs of the neurotic applicant. Gordon (2), Pollack (3), and Reiner and Kaufman (4), have analyzed the difficulties inherent in agency structure with relation to character-disordered applicants. Our concern for the character-disordered is further reinforced by recent studies of attrition rates in clinics (5).

The depth of the problem is evident in

the attitudes of schools, welfare departments and the courts, institutions immediately involved with the problems of disturbed children. Aware of the inadequacy of community social services, insti-

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tutions in such urban centers as New York, Detroit, Los Angeles and Philadelphia have attempted to develop their own programs for disturbed youth.

Our experiences with a predominantly Negro and Italian, low socio-economic population in a Philadelphia school district serving more than 20,000 school-age children suggests that the needs of many disturbed children may be served outside the framework of the traditional mental health agency. Consequently, we have sought to focus on the school and on the neighborhood settlement house as community resources in the secondary prevention of emotional maladjustment.

In this paper we will describe a program of collaboration between school personnel, a mental health consultant and a neighborhood settlement house, as that program was designed to meet the mental health needs of elementary-age school children, with emphasis on those children whose parents are rejecting or inadequate.

The Francis Scott Key School is located in South Philadelphia, one of the oldest sections in the city. Five hundred and fifty children attend the school; they come from Italian backgrounds, a decreasing Jewish minority group, and a rapidly increasing Negro group. The area is characteristic of other urban areas in the nation caught in the current of rapid social change. The Key School, because of its interest in meeting the mental health needs of its pupils, was selected to participate in a research program predicated on the early identification and treatment of emotional maladjustment in children. The choice was made by the district superintendent who later became chairman of an advisory committee composed of professional people from the disciplines of psychiatry, psychology, social work, counseling and education.

At the very start of the program it was

clear to the faculty and to the principal that the educative process in that area required re-examination in the light of changing responsibilities. The effects of economic downgrading, intergroup racial tensions and population mobility had serious implications for educators. It was evident that a significant number of children were not responding to the various adaptive and remedial practices offered in the existing program of instruction. Such practices included counseling, remedial teaching, and reclassification based on individual differences.

The experienced and competent staff had for years been sensitive to the needs of the community. That sensitivity was reflected in a deep concern for the problems of the student. Yet, many children were not learning, not because they lacked the capacity to learn or because the school lacked flexibility, but rather because their success in school was blocked by the same adverse, personal factors which prevented their living happy and meaningful lives in family and neighborhood settings.

Children failed to learn because they were frightened, angry, ashamed, unhappy and too defeated to reach out for learning. To compound the problem, behavioral symptoms expressed in the classroom disrupted the teaching process, to the extent that all the students suffered.

The school's placement programs provided for individual diagnosis and referral procedures. A review of the records indicated that 20 per cent of the pupils referred in a three-year period were classified as mentally retarded. The remaining referrals were children of normal or better intelligence who were disabled academically by their own emotional problems. Psychological evaluation of these children suggested the need for psychotherapy. Yet, it was not uncommon in the elementary schools, especially in all-Negro

neighborhoods, for not a single child to be in treatment. This, despite our estimates that the number of children needing help ranged from 5 per cent in stable neighborhoods to 25 per cent in depressed areas. Here indeed were children who had little opportunity to develop a potential for growth.

Interviews with the parents of these children tended to complicate the situation. Intervention by the school on behalf of the child was often viewed as a hostile and threatening action. The failure of the pupil was projected upon the school. Where recommendations by the principal or the counseling teacher were accepted, many of the parents, inadequate and overwhelmed by their own personal problems, were reluctant to seek help outside the neighborhood. Once referred, an insignificant number of children returned to the agency after the first few interviews.

A comprehensive program for dealing with a problem of such magnitude covers a great deal of ground. In the program developed at the Key School, our plan of action was threefold:

1. It was determined that all students in the Key School be screened for symptoms of emotional maladjustment.
2. Inservice seminars, under the direction of a professional consultant, were instituted for teachers.
3. It was hypothesized that a new approach to the problem of the disturbed child was needed. The opportunity for such an approach was explored.

It was our initial hypothesis that a majority of disturbed children in the elementary grades could be identified by the classroom teacher. To that end, teachers were requested to study the operational definition of maladjustment as developed by Bower and Lambert (1). On the basis of criteria suggested by that definition, teachers were asked to rate each child in the classroom

on a five-point rating scale, ranging from excellent adjustment to very poor adjustment.¹ An evaluation of teacher ratings indicated that 18.6 per cent of the school population were classified as maladjusted.² Our previous experience had taught us that very few of the 103 children so identified would be exposed to treatment or therapeutic guidance outside the school.

A second phase of the program was initiated as teachers expressed interest in learning more about teaching and managing the increasing number of "troublesome and troubled" pupils in the Key School. Inservice seminars were instituted under the leadership of a professional consultant. Case studies of individual students were presented by teachers who asked for ideas and advice from the consultant. In contrast with many seminars of this kind, the consultant did not hesitate to give his views with regard to a specific situation. In turn, the teachers seemed to appreciate a professional person who felt free to make suggestions in an atmosphere which encouraged discussions rather than uncritical acceptance of authority.

It was evident in the first few sessions that the teachers wanted to talk about the pupil who presented the most serious management problem in the classroom. Gradually, teachers came to realize that students who were not overt behavior problems might also have serious adjustment problems. Many teachers discovered that these troubled children were responding to their

¹ A modification of this procedure was used by one of the authors (Gordan) in the evaluation of 55,763 elementary school children in Middlesex County, N. J. Teachers rated 11.2 per cent (or 6,248 pupils) as maladjusted. An evaluation of this study is being readied for publication.

² Our studies indicate that teacher-rating scales alone are more successful in identifying disturbed children than the rating procedure developed by Bower and Lambert (1).

own inner fear, rage, disappointment and conflict, rather than to a classroom action by the teacher.

Gradually, teachers became aware that they could contribute to the emotional strengths of the child. They came to know that very often their own anger and hostility were stirred by the conduct of a child. When teachers became angry and defensive in the face of such conduct, they were unconsciously afraid of their own feelings. Finally, teachers discovered that the best "therapy" for most children was success with educational tasks. For many children, the school was the only place they could acquire a sense of personal worth and integrity.

Improvement in teacher reactions were evident. The teacher who tended to defend himself when a pupil failed, now attempted to probe the cause of such failure in terms of the child's performance rather than in terms of self-blame. More teachers discussed ways of dealing with problem cases instead of urging the principal to relieve them of the responsibility of such problems. They attempted to view, with understanding, the aggressive reactions of a child whose withdrawn passive behavior before "treatment" was of concern. Finally, teachers felt free to refer difficult problems to the principal without anticipating any reflection upon their own adequacy.

In turn, the principal avoided any supervisory practices which were threatening to the teacher's emotional security. That attitude by staff personnel contributed much to the teacher's ability to help the disturbed child without distracting from her basic role as a teacher to many children.

A secondary gain of the inservice seminars resulted from the decrease of "crisis" incidents and suspensions. The counseling teacher, the link between school and home, found it possible to report positive progress by the students. Parents were less

threatened by the school. As a better relationship developed between school and home, the interaction at parent-teacher conferences lost much of its emotional charge.

The collaboration between the Key School and the St. Martha's Settlement House began during the summer of 1959. The principal of the Key School and the executive director of the Settlement House were jointly concerned with a child whom neither the school nor the agency had helped successfully. The idea of a collaborative project to deal with the problem excited both men. Out of this discussion a plan was evolved by which some of the children in the school would be exposed to a modifying group experience where they could establish positive relationships with their fellow pupils and with an adult leader. It was felt that in this manner the anxiety experienced by the children would slacken to the extent that behavior in the classroom would improve. It was hypothesized that a general improvement in school achievement would follow.

An advisory committee was formed to guide and co-ordinate the program. The project was named the "Opportunity Club."³ The basic role developed for the school in the project took the following form:

A. Each of the Opportunity Clubs became a part of the school program. One of the two meetings held each week was conducted in the school during school hours; the other meeting was conducted at the Settlement House after school dismissal.

B. The school made the initial selection of the child with the help of an advisory

³A paper describing the Opportunity Clubs, entitled "Activity Group Psychotherapy with Seriously Disturbed Elementary School Children" was presented at the 1962 annual meeting of the American Group Psychotherapy Association by Gordon, Berkowitz and Cacace.

committee, and with the permission of the parent.

The agency role took the following form:

A. The Settlement House provided a group leader and a supervisor for the project. The services of the project consultant were also utilized.

B. The group leader submitted progress reports of all group meetings, individual conferences and parent contacts.

C. Agency facilities were made available to members of the group.

During the first two years of the project, a group was formed for boys ages nine to eleven. The group enrollment was set at twelve members. Efforts were made to keep the membership constant for a two-year period in order to provide the boys with a rich group experience. At the beginning of the third year a second group was formed involving younger children. At that time both groups were limited to ten members.

Our initial intention was to involve the parents in the project. We soon discovered that reaching out to the parents was ineffective. They were too overwhelmed by personal and family problems. As a result, our involvement with the home was limited to the initial request for permission which was prerequisite to group membership. We later communicated with parents when it appeared that children were making progress. We realized that most of the parents interpreted school progress by their children as an indication of their own adequacy.

Throughout the project, the formation of groups was grounded on the principle that the group experience provide the boys with a maximum of gratification and a minimum of frustration. A varied program was developed, including arts and crafts, athletics, with some emphasis on skills, quiet games (particularly during the

school session) and dramatics. Field trips were utilized both for their inherent educational value and to provide the boys with opportunities for meaningful planning. Discussions were an integral part of the program. The boys were encouraged to express themselves, first about the behavior of others, and later, to some extent, about their own behavior.

The group experience did provide a social situation where the boys were not threatened. The particular problems of individual boys were clearly manifested and observed. As a result, the members of the advisory committee were able to formulate further recommendations on the basis of empirical findings. As for the children, the boys who were members of the group for less than one year did not seem to profit greatly from the experience. Five boys who were group members for two years exhibited improvement in school attendance, and in academic achievement. Three of the boys brought their reading skill to grade level.

In almost all the cases, improvement was evident in school-home relationships. Later findings also indicated that in the younger group (eight- and nine-year-olds), improvement in achievement and behavior was evident after only one year in the group. Follow-up studies of all the boys are now in progress.

By June of 1963, the over-all program developed at the Key School had been in operation for four years. The results of the project were reviewed, and the following evaluations appear valid:

First, our experience at the Key School tends to show that teacher-rating scales are reliable indicators of emotional disturbances in children.

Second, our experiences suggest that academically retarded, emotionally disturbed children of normal intelligence can be helped to improve their skills. Such

children can enjoy school even if they come from broken or culturally shallow homes where the parents are inadequate.

Third, the popular notion that children cannot be helped without the active support of the parent is fallacious. In our judgment, the key to success with emotionally disturbed children lies in the identification and treatment of such cases at a time when modification of behavior is still possible.

Fourth, the role of the mental health consultant in the school setting was more clearly defined. We conceive of the consultant as a resource person grounded in the techniques and science of education, but with professional roots in psychology, psychiatry or social work. His role in the school would include the development of special programs with teachers, students and parents, as well as the guidance of administrative policy with regard to such programs.

Fifth, the settlement house is a valuable adjunct to the school for children of disturbed families who are reluctant to seek help outside the familiar neighborhood setting.

Sixth, the theory that many children fail to learn because they are unable to see personal implication in the curriculum content was clearly demonstrated by our study. The human realities of urban living are rarely presented to them in text books or in courses of study. Yet, the perceptions of the child are a very real dimension of the educative process.

There is a need for the kind of teaching which is in tune with the child's perception of himself and of his world. Such teaching would provide a climate for emotional as well as intellectual involvement. We are now exploring the feasibility of integrating into the curriculum of the Key School the products of our findings.

In conclusion, we are convinced that if

we are to make headway in the reduction of school dropouts, delinquency, mental illness and other disabling forms of emotional maladjustment, we must intervene early in the lives of the more disturbed families in our communities. As long as special social services are restricted, in practice, to children from well-motivated, middle-income families, the prognosis is poor for the great majority of emotionally handicapped youngsters.

Our experience at the Key School, where children from deprived and disorganized home environments characterized the experimental population, suggests that the key to "success" with such children falls within the framework of the public school setting itself, where the problems of the child are best identified and understood.

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Foster home variables and adult outcomes

In a previous paper¹ it was reported that certain features in the natural family background of foster children were ominously prognostic of their failure to become normally functioning adults, while others carried a better prognosis.

The present paper will consider features in the placement and handling of the same children which modified these prognoses and which thus could indicate the road to a more systematic matching of foster home to foster child than has hitherto been possible.

For the present, both the prognostic pointers and the matching which they suggest can be taken as valid only for the specific agency and setting studied, and only for long-term placements. Eventually, however, they could have relevance for foster care everywhere, and beyond that, for child development in general.

CASE SELECTION AND OUTCOME CRITERIA²

The basic data from which this series of studies developed comprised all the records in one Montreal agency referring to children having had:

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This study was carried out with the co-operation of the Children's Service Centre, Montreal, and with the support of the Grant Foundation, Inc., New York City. Mrs. Prabha Madan carried out most of the data collection and organization.

¹ Murphy, H. B. M., "Natural Family Pointers to Foster Care Outcome," *Mental Hygiene*, 48 (July, 1964), 980-95.

² This section is condensed from the previous paper, which should be consulted if more details are desired.

- (a) More than five years continuous foster-boarding care.
- (b) Termination of agency care before the start of the study.
- (c) An age of eleven or more at time of such termination.
- (d) No indication of frank mental subnormality or brain damage³

On each child meeting these criteria, family background and certain foster-period information were abstracted and coded for punch-card analysis, while at the same time the assessment of adult outcome was sought. Then, for approximately two-thirds the recorded information on the foster homes in which they spent their longest stay was abstracted and coded on a separate card.

The previous paper reported on the natural family backgrounds of the total 316 cases originally traced; the present one reports on the foster homes of the 114 whose natural backgrounds seemed to indicate the poorest prognosis, plus those of an additional 82 children (for comparison) whose natural backgrounds were apparently more favorable. In each instance the research has focused on apparent associations between rated outcome in early adulthood and specific features in the natural and foster families.

The outcome ratings were prepared (without any actual follow-up of the subjects) in terms of what news the agency had had of the adult or late adolescent adjustment of each child. Fortunately, this agency has good contacts with its former

charges and also with the courts, hospitals, family agencies and some employers in the city, so that news and inquiries about these former charges are continually passing across its desks. Fortunately, also, two of its officials—persons with unusually complete memories—had been continuously in charge of foster-care work over the years from which the records were taken, and were able to give later news on almost any long-term foster child one cared to name from that period.

Hence, although this method of assessment would have been impossible if one had been dealing with the hundreds of short-term foster children to whom the agency briefly gave shelter, and would have been highly undesirable if many case workers (each with their own subjective criteria) had had to be consulted, it proved both possible and acceptable in the present instance, given the broad standards of accuracy to which the rest of the study was geared.

Seven categories of outcome were used initially, but these were reduced to three for the later analysis. These three are:

- A. Outcome ostensibly satisfactory in terms of the child's social milieu;
- B. Outcome less satisfactory than A, but without signs of open pathology or social disturbance;
- C. Outcome unsatisfactory, usually with signs of pathological or antisocial behavior.

It is not claimed here that a "satisfactory" outcome rating in the above sense implies full mental health or absence of residual traumata from the foster-care period. Neither is it claimed that the assessments were made without personal bias, or in a completely consistent manner or in total disregard of the subject's behavior while in foster care (although the assessors

³ After displacement, many foster children exhibit traits which are superficially suggestive of mental retardation or brain damage, but which improve later. Accordingly, a single early report of apparent moderate defect or of possible brain damage was not taken as an indication for exclusion of a case from the study if later reports were lacking.

were asked to disregard this as far as they consciously could).

Broadly speaking, however, a "C" rating can be taken as indicating open personal or social breakdown, usually involving admission to a mental hospital, serious trouble with the police, chronic dependency on a welfare agency, or notorious family instability. Conversely, an "A" rating implies successful conformity with the local norms of steady employment, stable marriage, realistic career goals, etc.

The ratings were arrived at jointly and a recheck of a random sample showed the two assessors to be in close agreement. A follow-up of another sample of the subjects, with psychological testing and direct assessment by the researchers, is planned for the future, and a clinical study of current foster children and foster homes has begun, but these are not intended to supercede the original ratings. Since it was felt that the "C" ratings more objectively reflected malfunctioning than the "A" ratings could be said definitely to reflect good functioning, it was decided to focus mainly on the differences between the "C" group and the rest in the analysis.

NATURAL FAMILY VARIABLES

While the previous paper must be referred to for a full discussion of the associations found between outcome rating and natural family background, it is convenient to summarize the main findings here, since they determine what will be called the "poor risk" and "good risk" categories of child. It must be understood that for the natural families, as for the foster families, only those variables could be investigated which were routinely covered in the agency records, rather than those it might have been most logical to inquire into, had the research been working with the subjects themselves.

The main associations between background and outcome proved to differ with the sex of the child. For girls, the strongest pointer was the structure of the family and the nature of its collapse, as viewed at the time of the child's first placement. If both parents were still together, or if the family had been broken by death or illness, then girls from such families almost never showed the frank breakdown that would merit a "C" rating, regardless of the earlier behavior of the natural parents and of later foster-care experiences.

If, on the other hand, the mother was unmarried at the time of placement or the family had been consciously abandoned by its partners, then girls from such families ran a heavy risk of turning out unsatisfactorily (at least to the age to which our assessors had followed them) regardless of what contact they might have with the natural parents in the foster period.

With boys, the associations between these variables and outcome, although present, is quite weak. However, if one adds the further question of whether or not there was frank alcoholism or mental disorder in the parents, then the combination is of strong prognostic import, even though mental disorder in a parent is *of itself* of no apparent prognostic import whatever.

For both sexes, the question of whether or not either parent shows enough personal stability and interest in the child to maintain regular contributions to his care is relevant, and for boys the degree of rejection implied at time of placement or later is also significant.

For girls, however, the association between parental visiting and outcome is more complex, since frequent visiting by a natural mother is associated with poor outcome. Age at placement, somewhat surprisingly, proves of little relevance by itself, but in combination with certain

other variables it becomes important for certain categories of child.

There are two methods of using such findings. The better but more complex would be to calculate weights for each category of relevant variable, and then to derive an individual probability of poor ("C") outcome for any particular child. The easier is to prescribe a few general rules whereby to place all children into one of two categories; namely, "poor risk," where the family background was unfavorable and the need for supervision great, and "good risk," where the family background was favorable and supervision could be relaxed. The latter method was chosen for the present, since it was more convenient for the agency and for the task of assessing the influence of the foster home on children of different backgrounds.

In the previous paper one such method of separation was given, making use of family structure at time of placement, financial support during foster care and most of the other indicators mentioned above.

For the present paper a slightly less sharp but essentially similar division has been used which put 114 children in the "poor risk" category and 198 in the "good risk" category. All of the 114 "poor risks" are studied here, since we are particularly concerned with preventing unsatisfactory outcome. However, it was suspected—correctly, as it turned out—that a successful foster home for a "poor risk" child might not be the best for a "good risk" one. Therefore, although time did not permit the study of the total "good risk" group as well, a sample of 82 from the latter has also been included.⁴ There are no "C" outcome children in the latter sample, and when

they are discussed it will therefore be in terms of a ratio of "A" to "B" ratings obtained, not in percentage of "C's."

THE LOCATION OF THE FOSTER HOME

In general literature on foster-care planning, emphasis in the past has usually been placed on avoidance of multiple placements, on a warm and loving foster mother, and on clarity in explaining to the child his relationship to the various adults around him. The variable which proved most strongly associated with outcome in the present material, however, was none of these. To our surprise and dismay, it proved to be the residential location of the foster home. As is seen in Figure I, "poor risk" children spending their longest foster stay in a suburban home have a much higher percentage of unsatisfactory outcomes than those spending their stay in either a city or a rural home. At the same time, "good risk" children placed thus in suburban homes get a lower percentage of satisfactory ("A") ratings than those placed elsewhere.

At first discovery it seemed plausible that this association would prove secondary to some more intimate characteristic of the family or of the foster mother. That is to say, we expected that suburban foster homes on the average would be of a different social class, or would have different motives and different goals, or would have fewer own children in them than city or country homes, and that these would have a more basic association with outcome.

The first part of this expectation proved true, at least in part, for there are certain differences between city and suburban foster families with respect to number of own children, etc., but the second did not. All possibly relevant variables on which information was encoded have been explored, and although some of them do show

⁴ To provide better contrast, the 82 were chosen from the most favorable backgrounds, and cases where the classification into poor or good background was difficult were avoided.

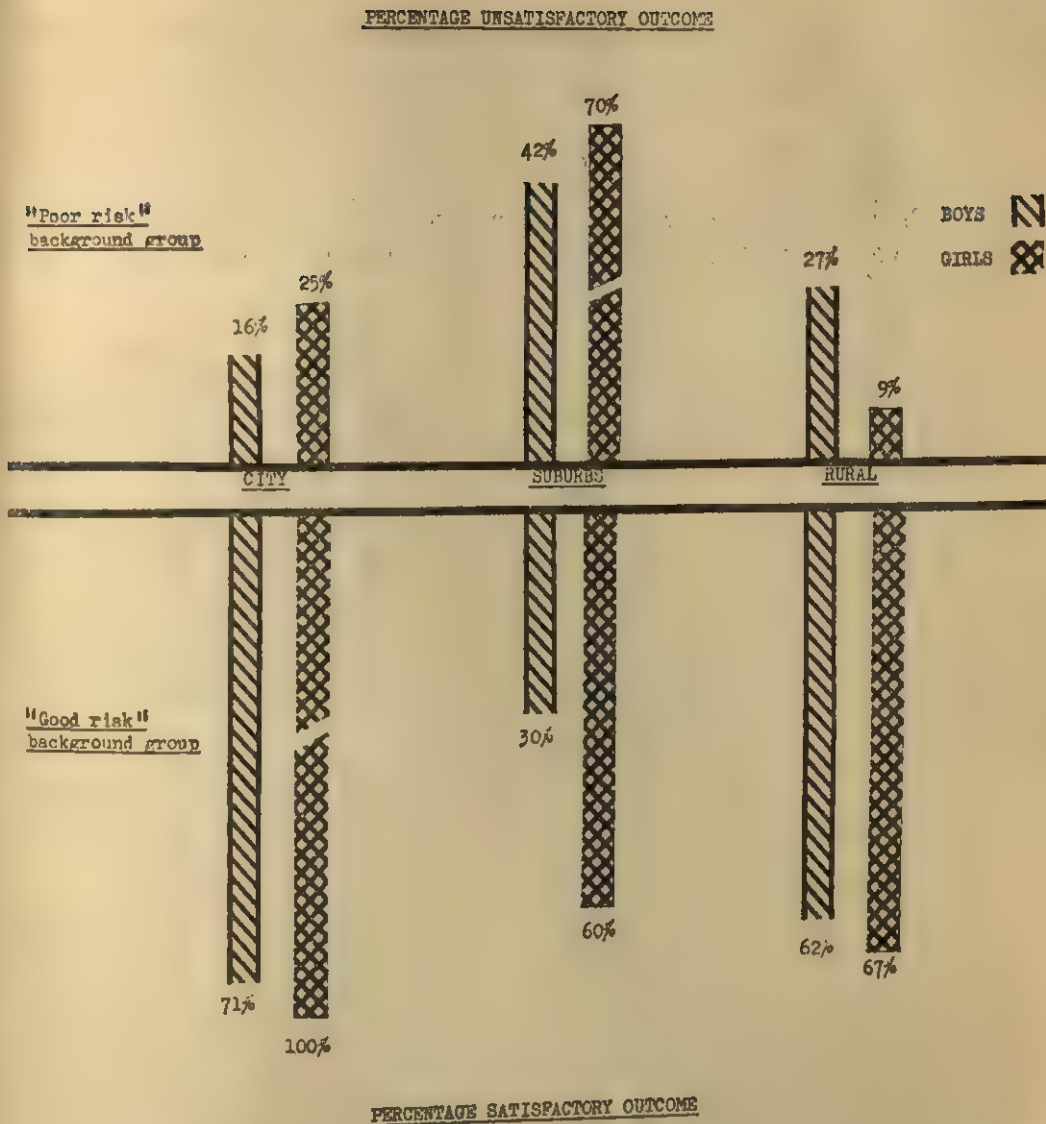


FIGURE I

Proportion of unsatisfactory and of satisfactory outcomes in foster children, according to zone of residence of their longest-stay foster home; by "poor risk" and "good risk" categories of natural background, and by sex.

an association both with outcome and with suburban living (as will be shown below) the residential zone factor overrides them all. Moreover, division of the suburban

zone into different sectors, despite marked differences in social character between one sector and another, did not point to the poor outcomes being associated with any

particular neighborhood. One sector of older construction than the rest proved to have lower rates than the others, but this was all.

While the matter calls for more investigation, therefore, we have regretfully concluded for the present that suburban life, regardless of the characteristics of the individual foster home, has an adverse influence on city children placed in foster care there. Earlier it was mentioned that we view the findings with some dismay; this is because in Protestant Montreal today new foster families are offering themselves almost wholly from the suburban sectors.

Differences between rural and city homes, which might have been expected to be more relevant, proved almost negligible. Boys, especially if they are first placed in the home after the age of ten, do less well in the countryside than in the city, whereas with girls the position is reversed. However, these differences are not great.

RESIDENTIAL MOBILITY

One of the possible explanations for the poor results from suburban homes is that the children are removed from their old societies and are not supplied with a new, cohesive and accepting society such as some city neighborhoods and many country towns provide. This hypothesis is given some support by the fact that the outcomes of "poor risk" boys, regardless of zone of residence are worse if the foster family moves than if it does not ($p < 0.10$). This difference does not apply to girls, and, although present, is negligible in the case of "good risk" boys.

Analysis by distance of move shows, as one would expect, that displacements which involve change of school and of neighborhood are followed by poorer outcomes than displacements which do not in-

volve this. However, this does not explain the difference between boys and girls in relation to this variable. Girls who join a city family which then moves to a suburban area show much better outcomes than those who join a family already in the suburbs, but numbers here are too small for any weight to be put on the point.

THE FOSTER MOTHER

It was mentioned above that warmth of affection did not come up as an especially important variable in our findings. This may be in part because we had no satisfactory and objective indicator for it, or because the agency refuses to use foster mothers who are not affection-giving. However, indirect evidence suggests that when assessing a mother's ability to give affection, one should also pay attention to her need to receive something in return, and then to the foster child's ability to give that something. Variables reflecting different traits in the foster mother's personality do prove to be highly related to outcome, but the data suggest that different types of children do best with different types of mothers.

The foster-mother variable which proved to be most clearly associated with children's outcomes is one which is rather remote from the actual fostering situation, and hence must be taken as an indicator of some important underlying trait rather than as a factor in its own right.

At the time of recruitment (which may be many years before the studied child was placed with the family), all mothers are asked about their motives for undertaking the work, and about the age, sex and number of children they would prefer. The declared motive proves to be relevant only if it is such as can be labeled altruistic. Mothers giving this type of reason do significantly better than other mothers with boys from "poor risk" backgrounds, but

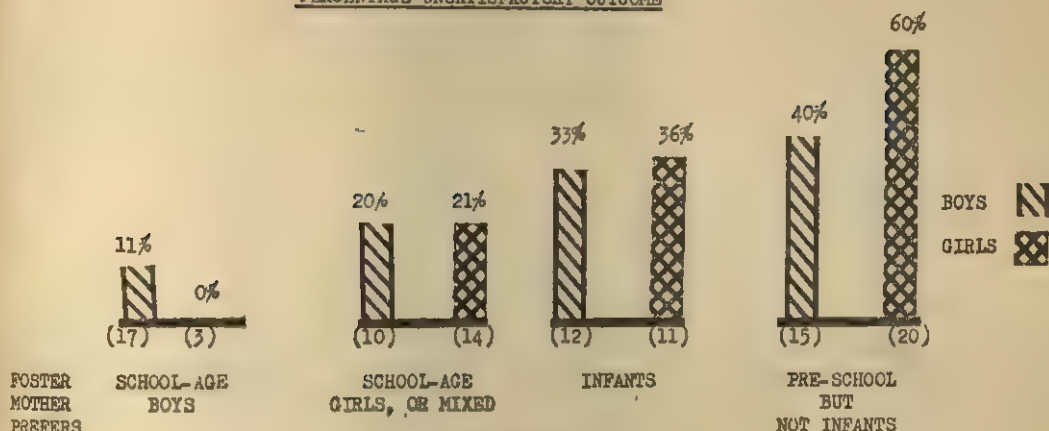
PERCENTAGE UNSATISFACTORY OUTCOME

FIGURE II

Outcomes of foster children related to the age and sex preferences of the foster mother with whom they spent their longest foster stay, by sex; for "poor risk" children only

not better than average with girls or with "good risk" boys; and they are, in any case, a minority.

The answers regarding the preferred age, sex and number of children, however, are highly indicative of outcome, irrespective of the actual number, age and sex of children received. There is a fairly high correlation between preferring older children, preferring boys, and being willing to take more than one child; and mothers showing this combination prove to be the most successful with "poor risk" children, especially girls.

Figure II shows this point, and at the same time indicates that the least success is obtained by those mothers who declared a preference for the type of child (i.e., pre-school) that is the most responsive and submissive to affection and domination, and at the same time gives the least work. Moreover, if for simplicity we divide the mothers into those who prefer schoolage and those who prefer preschool children (including infants), then the next figure (III) shows that this variable is independent of the

residential zone factor previously discussed, so that their effects are cumulative.

Mothers residing in the suburbs and preferring younger children thus have the unenviable record of seeing 17 of the 22 "poor risk" children from the sample entrusted to them turn out unsatisfactorily whereas city mothers preferring older children experienced this in only 2 of the 19 they handled. A most striking difference!

To the experienced case worker, the failure of mothers preferring the younger, easier child may come as no news, since it is recognized that there are mothers who are excellent at caring for babies and yet hopeless with adolescents, while others are good with the older group but impatient with the younger. However, the foregoing findings referred to the difficult, "poor risk" children, and when one turns to the "good risk" group the picture is quite different. With them the mother who prefers a younger child does no worse than average if the child is a girl, and actually does better than average if the child is a boy. Hence, since "good risk" children exceed "poor

PERCENTAGE UNSATISFACTORY OUTCOME

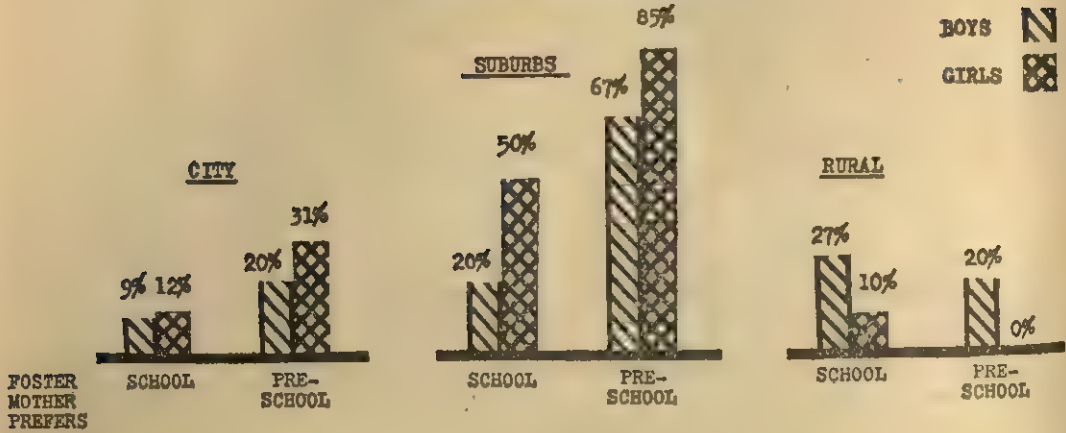


FIGURE III

Outcomes of "poor risk" foster children; by location of foster home and by age preference of foster mother

risk" ones, there is no need to consider this latter type of mother as unsuitable for foster care, but merely as unsuitable for a particular type of child.

No other attitude or attribute of the foster mother comes as close to being a prognostic indicator of outcome as the foregoing do, but some show a moderate association independent of the above and are of interest. One is her attitude toward the natural parents of the placed child.

Over much of the period surveyed the agency has made it a rule (not always obeyed) that a special report be prepared on a new foster mother's first case; and this usually includes a note on her relations with the natural mother. Although these notes usually do not refer to her relations with the natural mother of the children sampled for this study, it is found that they do have some prognostic relevance for the latter. If actual quarreling is reported, which is only in 9 cases, this is of definitely poor prognosis even for later-placed children, since none of the latter

received an "A" rating. If a welcoming attitude is reported, however, the prognosis is not necessarily favorable.

With girls and with "good risk" boys, outcome is unrelated to whether the foster mother is a welcoming type or merely a tolerating one, while with "poor risk" boys the outcome is actually better if the foster mother is merely tolerating than if she is frankly welcoming (significant at the 0.042 level, using Fisher's exact test for 2 x 2 tables). The possible meaning of this will be discussed below.

Another possible and less expected factor connected with the relationship between foster mothers and natural mothers is relative age. We did not find any significant association between outcome and the foster mother's age *per se*, but in the case of "poor risk" girls there seems to be a definite advantage in the foster mother being moderately older than the natural mother, but not so much older (15 years or more) that the latter cannot react to her as she

would to her own mother. Since some ages were discreetly omitted from the records and since the zones of residence complicate the picture, the finding cannot be taken as unquestionable, even though statistically valid ($p=0.025$). However, the point did appear to be worth mentioning here, since it does seem possible that the natural mother would get on less well with a foster mother whom she could look down on, age-wise, or who could reawaken her own ambivalences towards her own mother, than with one who could be treated as a slightly more senior peer.

These interrelational variables, with their limited application, are of much less value in the planning of foster placements than those reflected by the foster mother's preferences regarding the age and sex of the child. The final association to be mentioned at this point may be more useful, again, in Montreal, since it has a higher validity, but outside of that city it has probably only a theoretical interest. It relates to the foster mother's cultural background.

For historical and possibly for cultural reasons, the Children's Service Centre of Montreal, whose data are being used here, has found its foster mothers mainly among women born in Britain or, more recently, in continental Europe. (At one time, the agency did not have a single foster family that was wholly North American-born, even though its channels of recruitment should have brought many of them in.)

On the other hand, the natural family background of most of its foster children was wholly American (inclusive of the Caribbean area), and the possibility thus existed of the average foster mother having culturally-based expectations which were foreign to the children's society. Such a difference could, in theory, be as potentially harmful as the much more widely known difference between the middle-class foster

mother and the lower-class child, and the matter thus called for investigation.

Three concrete results have appeared. In the first place, the eight foster mothers included in this study who were born in continental Europe obtained exceptionally good results from the children given them, regardless of sex, age or background. Their number, however, is so small that it would be risky to generalize from it, even for Montreal.

Secondly, foster mothers born in rural Quebec achieve significantly better results with "*poor risk*" children than do those born in urban Montreal, elsewhere in North America, or in Britain. These rural-born mothers tend still to reside in the rural zone, which gives them an advantage, but they are successful with "*poor risk*" children even when they live in the city.

Finally, with "*good risk*" children, urban-born North American foster mothers obtain significantly better results either than rural-born or than British ones.

It is not suggested that other agencies can make use of this finding or even that the mothers are representative of the nativity group to which they belong. Nevertheless, the finding does suggest that other agencies may find it profitable to consider the backgrounds of their foster mothers with a view to seeing whether that background offers an indication of the type of child the mother is best suited to.

THE FOSTER FATHER

None of the other personal characteristics of the foster mother which we could explore proved significantly relevant to outcome after residential zone and the factor indicated by age preference had been taken into account.

Concerning the foster fathers, regrettably little was given in the records from which

we had to work, but one interesting and significant point came out.

Their occupations were classified roughly into five categories—farming, white-collar, skilled manual, semiskilled and unskilled manual. The natural family backgrounds of the children themselves can be assumed to fall almost wholly within the last two of these. Where foster fathers were in the semi- or unskilled category and had only grade-school education, the impression obtained is that they succeed adequately with easy children and fail moderately with difficult ones; but this differences does not reach statistical significance. Where they were in the white-collar and in the skilled manual categories, however, a difference does appear in relation to boys, although it is one which is difficult to demonstrate because of the other variables for which we need to allow.

Briefly, "poor risk" boys placed with foster fathers in the skilled manual labor category do exceptionally well, especially if the foster mother is of the type that prefers older children, while those placed in white-collar homes do relatively poorly. With "good risk" boys, however, the posi-

tion is reversed, since the white-collar homes produce almost only "A" rated boys, whereas those in the skilled manual class produce fewer "A's" than "B's."

Since numbers are small, not too much weight can be put on them, but the picture from the analysis of foster parents by education reinforces the impression given and suggests a general rule to be discussed later.

THE FOSTER-FAMILY STRUCTURE

The foster parents are not the only individuals within a foster home who can influence a child's life; there can be other adults, the foster parents' own children, and other foster children playing their part. Other adults, including visiting foster-grandparents, probably have a considerable influence, but unfortunately, records did not inform us sufficiently about them for the data to be worthwhile analyzing. The presence, age and sex of the foster parents' own children in the house, however, could be calculated or deduced, and these have proved to have some relevance.

In the first place, homes in which there is any own child older than the studied

TABLE 1

Foster Parents' Own Children in Home	Girls Only			
	"GOOD RISK"		"POOR RISK"	
	(N)	B%	(N)	C%
None	{ (18)	46%	(29)	41%
Younger only			(11)	77%
Older and younger	{ (9)	0%	(3)	33%
Older only			(11)	0%

Outcome of girls as related to presence and age of foster parents' own children in the home; for "good risk" and for "poor risk" girls separately

TABLE 2

Foster Mother Expressed Preference for Preschool Foster Child, and:	Zone one.....City		"Poor risk" girls only Suburban	
	(N)	C%	(N)	C%
a) Has own older child at home	(6)	0%	(2)	0%
b) Has no own older child at home	(10)	50%	(11)	100%
	(16)	31%	(13)	85%

Outcome of "poor risk" girls in homes where foster mother has expressed preference for preschool child; by residential zone and by presence of own older child in home at time of foster child's stay. (The rural zone has been omitted since foster mothers there almost wholly prefer older children.)

foster child seem particularly favorable for both "poor risk" and "good risk" girls, whereas homes in which there are only own younger children do least well.

The latter point; namely, the poor results where younger own children are present, may be accidental, since such homes tend to be found in the suburbs or to have foster mothers who had shown a preference for younger children. However, the association between good outcomes and an older own child in the home is undoubtedly relevant, since it applies in all residential zones and with both categories of foster mother's preference.

Moreover, as Table 2 shows, the presence of the older child is particularly worth while noting where the foster mother has expressed a preference for a preschool child and where the foster girl is in the "poor risk" category. A review of the histories suggests that this picture may be due in part to a confusion of two types of foster mother: those who desire a young child for their own sakes, and those who desire one so that their own older children may have a means of learning to look after children.

However, surprising though it may seem, the association with good outcome in girls applies whether the own older child is girl or boy. Hence the relevant variable may lie in the family structure or in the intermediate role model offered by the own child, rather than with the foster mother herself.

The second finding on this point is that although boys are not affected, apparently, by the presence of an older own child, they are, if they are in the "good risk" category, affected by the presence of the foster parents' own children generally.

This does not apply, for reasons unknown, in rural families, but in city and suburban families, the percentage of satisfactory ("A") outcomes is significantly better if the longest-stay home had own children in it than if it had none ($\chi^2=4.65$; $p<0.05$).

DISCUSSION

In the associations between outcome and natural family background, one of the more interesting points to appear was the fact that boys and girls were apparently

not equally susceptible to the same types of stress. Girls were markedly affected (judging from their assessed outcomes) by the *structure* of their natural family, by the model which their mothers presented to them, and by their position or rank within that family. Boys were more affected by drunkenness or mental disorder in a family (if it led to disturbed behavior in the home), by parental rejection, by the amount of support given during the foster-care period, and by indications of acceptance.

Similar differences can be found in relation to their foster-home experiences. Boys are sensitive to the presence of other children in the home, young or old, just as they are sensitive to moving residence, but girls are sensitive only to their position within the rank of these other children and are relatively unaffected by the home changing its location.

If the foster girl is the oldest child in the foster family (ignoring transient other foster children) then if her background is unfavorable she is likely to react unfavorably, whereas if she has a stable older child to look up to and upon whom to model herself, she is likely to do well despite an unfavorable background.

Again, if the foster mother has indicated through her preferences that she feels herself quite capable of handling older children and does not have pressing personal needs for affection or for responsiveness such as a preschool child would best meet, girls do well with her despite an unfavorable background. "Poor risk" boys also do well with such a mother, but they do even better if the mother's motives are altruistic and if the extra income, the usefulness of an extra hand around the house (especially on farms), or the desire for company can be assumed to be out of mind, so that only the child himself is important.

Moreover, "good risk" boys actually do

better with the mother who prefers the young child (and thereby reflects her own needs) than with the more independent mother, and we might interpret this by saying that this is the type of mother with whom affectional ties are likely to be strongest, provided only that the child has the capacity to respond to her needs.

For the same reason, probably, "poor risk" boys (but not girls) succeed better when the foster mother is cool toward natural mothers and perhaps jealous of the child's affection than when the natural mother is welcomed and hence probably shares in the foster mother's attention. But it was especially girls who turned out unsatisfactorily when foster mother and natural mother could be expected to clash.

It is clear, therefore, that foster boys and foster girls should be given different handling if they are to be long in care. The traditional desiderata of warmth and affection are still to be sought for, where boys are concerned, but with a girl it seems better to find her a strong and accessible older girl or woman upon whom she can model herself.

The present paper suggests a further general separation of children and homes, however. In a number of instances, qualities which seemed conducive to poor outcome when the child came from an unfavorable background and was "poor risk" proved to have no apparent relevance for the "good risk" child, and even to be conducive to a good outcome. One such point just mentioned concerned age preference, since mothers preferring younger children saw significantly better results from their "good risk" boys than those preferring older children, but got significantly poorer results with "poor risk" boys than the latter.

Another concerned the foster fathers' occupations and (since the difference did not apply to girls) presumably the role model

which they presented to foster boys. The white-collar group saw exceptionally good results with the "good risk" boys, but poorer than average with the "poor risk" ones; the skilled manual worker group saw just the reverse. Yet a third concerns the foster mother's cultural background, with the rural-born doing best with "poor risk" children and the urban-born with the "good risk."

Seeking an explanation for these differences, the most probable that comes to mind relates to the effect of natural family background on the foster child's capacity to respond to different levels of expectation. If we assume that unfavorable preplacement experiences reduce a child's capacity for social response, whereas favorable preplacement life may combine with the greater variety of foster-period experience to increase a child's social skills, then the foregoing findings become explainable.

The "poor risk" child needs a relatively low level of expectation, presented to him with clarity and concreteness. We imagine that this can best be found among mothers who need little emotional response from the children, among fathers who have concrete skills and limited ambitions, and in rural families where traditions are likely to be stronger and the goals and processes of their life less questioned.

The "good risk" child with an average intelligence and with his foster experiences to set him thinking and questioning, however, can be expected to do best with foster parents who can increase his self-esteem and security by indicating that he is needed, or that they expect him to achieve as well as any other child in their society, and who can assist him to identify with the urban middle-class norms and strivings that are taught him in his school, by his peers and perhaps by the agency case worker.

Thus, it does seem useful to attempt as-

essment of the damage which preplacement experiences have produced in a child, and of his capacity for social response, before selecting a foster home for him. This can be done, as in the present paper, by a rough separation into "poor risk" and "good risk" on the basis of the family history; or by a more refined assessment of individual experiences; or it can be attempted through psychological testing.

There remains the interesting but disturbing finding that suburban homes achieve so much poorer results than urban or rural ones, regardless of sex and background. It is not possible to say at this time whether the association should be taken as general (as is presumably the case with the other associations discussed above) or as peculiar to Montreal. Nor is it possible to say whether it is as relevant to the Montreal of today, with its relatively stable and organized suburbs, as it was when these suburbs were a confusion of summer cottages, farms, brick homes and squatters' shacks. But analysis of the data by year of placement has revealed no indication that the urban-suburban difference in average outcome is getting narrower. The matter must be investigated elsewhere.

However, the literature on suburbia⁵ suggests that families become less secure about their own values, about their neighbors, and less easily interacting with others in this setting. Therefore, it may be either that foster children there lack the social support of the country or of their old society in the city, or that they sense the foster mother's insecurity in her suburban role and hence cannot develop a sense of security in themselves.

⁵ The present paper is concerned only with the results from the Montreal study. A discussion of the relation between these findings and those of other workers will be presented in a future article.

Pragmatic psychiatry and traveling community mental health clinics

INTRODUCTION

The total population of the state of Utah in 1960 was 890,627. The principal population is concentrated within a 60-mile radius of Salt Lake City and accounts for 80 per cent of the total population of the state.

The psychiatrists (a total of 43) are located within this north central area, giving a psychiatrist-population ratio of approximately 1:16,000. The remaining 180,000 people are distributed over approximately 75,000 square miles with a county population density varying from 0.47-32.7 persons per square mile. The discussion will be limited to the depopulated areas of the state which do not have adequate psychiatric treatment facilities.

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Ten of the fourteen community mental health programs under partial subsidization from the state Department of Mental Health are located in the depopulated regions of the state and are operated as traveling mental health clinics. The professional personnel who spend one to two days per month in a community have been contracted by the individual areas and represent persons in private practice or with university affiliations.

The clinics operate on a once-per-month basis and appointments vary in length from fifteen minutes to one hour depending on the nature, severity and chronicity of the problem. Family therapy has been used in many areas for as long as four years to reduce the clinical load and to increase therapeutic effectiveness. Group therapy is in various stages of development and dependent on the availability of a co-therapist, such as a school counselor in the community, who can see the group on a weekly

basis between clinic visits. University trainees in psychiatry, psychology and social work are assigned to several of the clinics as ancillary personnel and supplement the clinic team composed of a psychiatrist, clinical psychologist and psychiatric social worker.

STRUCTURAL CONSIDERATIONS

Each community has a mental health advisory council composed of county commissioners, school board representatives and civic leaders, including physicians, nurses and local businessmen. The community advisory council meets three to four times yearly to discuss various problems, including those of budgeting, anticipating needs and taking under advisement future planning in the mental health program. The psychiatrist-director is directly responsible to them.

Since the enactment of the state mental health legislation in 1960, the communities have had partial subsidization for financing clinic operations. Although the state Department of Mental Health has requested compliance to certain broad operational policies, they have not actively participated in the administrative or policy-making decisions on a local level.

Key positions are occupied by the community public health nurses who act as liaison officers between the advisory council, the schools, the agencies, the community and the clinic team. They are responsible for the scheduling of patients and meetings and are frequently called upon between clinic visits to evaluate and make recommendations. They are long-standing community members who are frequently close friends of those seeking professional help through the mental health clinic. Since they are very conscious of the doctor-nurse chain of command, they have

difficulty relating to the paramedical team members. Their relative freedom and independence as public health nurses with other responsibilities make it difficult for them to operate comfortably as a member of a team. Although they should be included as an integral part of the clinic team, they resist this identification and function as an autonomous social unit.

The traveling clinic team is composed of members from the same geographic metropolitan area (Salt Lake City.) Many of the team members work in the same department and have daily contact during the rest of the month. Team members are on a first-name basis and have warm working and social relationships. The team consists of a psychiatrist, clinical psychologist and psychiatric social worker, with occasional trainees in the respective disciplines for varying periods up to one year. The trainees who are not permanent members frequently contribute valuable insights because of their objectivity as transient observers. They seem less hampered by emotional investments that carry with it the danger of psychological blind spots or the tendency to relax into a comfortable way of working.

Lastly, there are those institutionalized segments of the community that are the direct recipients of our services and consultations and include the schools, churches, various social agencies and the medical groups. Each has a structural and functional relationship that need not concern us in this discussion.

FUNCTIONAL CONSIDERATIONS

The community seeks a solution for its lack of mental health facilities and solicits the professional services of a psychiatric team. The credentials of the team members must be accepted on hearsay without

the knowledge of how best to judge their integrity and capabilities. Furthermore, the team members are frequently from the academic centers and are viewed as strangers who appear foreign and sometimes awaken fears among members of the community advisory council who may be self-made individuals without formal education. The professional fees necessary for contracting the team appear prohibitive and require local legislation of money which could be utilized in more tangible local projects.

From the outset, the community and the clinic team begin to approach the problems of mental health from different camps. The team emphasis is for healthy ego change and transcends the therapeutic hour to include the community. The community on the other hand seeks to offer treatment to those individuals who are unable or unwilling to conform to the status quo. It favors the encapsulation of the clinic functions and has difficulty accepting the clinic team as an integral part of the community or in the role of a community consultant. These differences of values and goals become manifest in overt and covert resistances that contribute to the strains in their working relationships with the clinic team, the Department of Mental Health, and the public health nurses and other social units.

The state Department of Mental Health has contributed a budgetary outlay for the partial financing of community clinics and has been instrumental in standardizing statistical reporting throughout the state. The Department has sponsored various workshops and offered consultation services, but is relatively uninvolved on the local level. Yet its presence is felt and many resentments are verbalized toward this group as it becomes a convenient scapegoat for the various social units involved with the community mental health pro-

gram. Phrases such as "state control," "they can't appreciate local problems," "they are only concerned with paper work," are heard periodically and reflect the apprehension of the community members.

The public health nurses spend approximately 15 per cent of their working month in connection with the mental health clinic functions. Their primary responsibility centers around scheduling patients and following up on missed appointments. They are passive participants in staff conferences and inservice training meetings and do not take an active role in the treatment process. Because of their varied responsibilities as public health nurses, they are frequently overworked and the strains become manifest in complaints regarding minor changes in ongoing schedules.

Many of the nurses are older women who received little or no formal psychiatric training in the prephenothiazine era. They manifest a rigid conformance to the doctor-nurse authority system, and seem to feel uncomfortable and unsure of themselves in a less formal system of communication. Attempts on the part of the clinic staff to teach dynamic principles in psychiatry are met with passive resistance, adding to the strains of a busy two-day clinic where 100 or more patients may be seen by the three-man clinic team. Examples of the resistance can be seen in forgetting to schedule patients or to notify them, playing into patients' defenses following appointments, or defending patients in staff conferences by focusing on citizenship, religious affiliations and the length of friendship.

Functional considerations of the traveling clinic team will not be discussed, recognizing the importance of its analysis in a later paper. It is enough to say that during the working day there is little ongoing communication because of the heavy scheduling. Evenings are spent discussing prob-

lems, administrative functions and ideas to be put into a working construct on the following day.

AN APPROACH TO THE PROBLEM

There are no absolute answers, since the community is a dynamic evolving social unit, and many of the approaches have been adopted through trial and error. Clinic members have the distinct disadvantage of being marginal participants, since their presence is only felt two days monthly and their range of contacts is limited. Frequently, it is necessary to compromise so that long term goals can be realized. Recognition and understanding of community dynamics are helpful in acquiring the patience and the formulation necessary in dealing successfully with what amounts to the treatment of a community.

The clinic receives frequent requests for evening discussions with PTA groups on problems related to school children, but not from the various service groups within the community. It was felt that this was an unconscious attempt to isolate the clinic from the community. Active measures were taken to obtain speaking engagements with the service groups, and it was discovered that in a community of approximately 5,000 the majority of citizens in service organizations were uninformed regarding the existence of the community mental health clinic, even after three years.

Initially, service group lectures were given in nonthreatening and sometimes nonpsychiatric areas, with a brief mention of the services available to the community through the mental health clinic. This was done to allow them to develop a healthy curiosity regarding the clinic function and to dilute their fears about psychiatry and the mental health fields.

The necessity for active community participation is obvious in a mental health

program on a once-per-month basis. The emphasis is being slowly focused away from the patient and toward the community. Instead of talking in terms of mobilizing a given patient, we have started to discuss problems in terms of mobilizing the community. This is being accomplished in a variety of ways.

Inservice training seminars have been instituted and opened to key personnel within the community to discuss recognition and management of a variety of common problems encountered. The structure of the seminars is to de-emphasize factual psychiatric data and to begin activating interest and understanding in developing a philosophy toward mental health. The clinic is offering supervision and consultation services to clergymen and school counselors who are seeing people independently. In cases where they have over-extended their professional capabilities, it has allowed them an opportunity to withdraw comfortably through referral and still maintain their social status and professional identity with the mental health clinic.

We are constantly looking for people in the community who have natural skills for handling emotional problems, and to involve them in the therapeutic program. The team is currently laying the cornerstone which will eventually allow the participation of volunteer workers to schedule appointments and to participate in treatment plans for disturbed individuals who need meaningful interaction with other human beings. We are involving service organizations in sponsoring programs that will be preventative rather than therapeutic. The two areas needing the greatest attention are day care nurseries for those in the preschool group and recreational camps and projects for adolescents.

The community identification of the

mental health team as being foremost a fee-for-service group is gradually being converted into a resource and consultation group. Within a relatively short period of time, the team has been able to free the psychiatric social worker of interview hours to the point where she can now spend half her time within the community consulting with various agencies.

Similar plans are anticipated for the clinical psychologist to better utilize her skills in advising and consulting with the schools and law enforcement agencies. The psychiatrist is continuing to involve the family physician in the management of the common psychiatric problems and to develop added skills in this area.

SUMMARY

The brief consideration of community dynamics and the difficulties involved with the establishment of traveling community mental health clinics are presented. A solution requires an adequate understanding of the community and the social processes at work. The treatment of a community for the establishment of a therapeutic community in the truest approximation includes consideration of the multiple variables of resistance encountered and to find satisfactory methods to resolve the conflicts and to mobilize the entire community into an effective therapeutic unit.

MICHAEL J. PACELLA, M. A.

The concept of a community mental health clinic: Fact or fiction?

Not long ago the nation's television viewers saw a short spot commercial showing a well-dressed young man playing bridge at a small social gathering. Obviously upset, he suddenly rises, throws his cards down angrily and leaves the room. The other guests appear distressed and concerned as the announcer's voice quietly explains that this upset person does not want to act this way; rather, he is emotionally disturbed, and therefore needs our understanding and help.

In a way not previously attempted, this brief television message illustrates quite clearly that mental illness is not necessarily something bizarre or spectacular, but is instead a pattern of behavior—brought about by one's own emotions—which is disruptive to normal human relations.

This message, sponsored by the National Association for Mental Health, is typical of the more sophisticated and well-planned

attempts to educate the public on what mental illness is and what should be done about it. Until now, mental illness, although by far the greatest health problem of our nation, has not been properly brought to the attention of the public.

Now, through the techniques of the mass media there is a growing awareness of our national mental health needs. One major factor leading toward a more effective program for mental health was the publication of *Action for Mental Health*, the final report of the Joint Commission on Mental Illness and Health. Of even greater importance as a major breakthrough in our national awareness of the problem was President Kennedy's message to the Con-

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gress in February, 1963, calling for "a bold new approach" in the battle against mental illness and mental retardation. In his message, the President recommended federal aid to support an expanded program of research, to encourage the development of comprehensive community mental health centers offering a broad spectrum of services, and to provide for the training of mental health personnel to meet the present manpower shortages.

As we view these developments, the weary though dedicated workers in the field of mental health may now take some measure of satisfaction in knowing that the enormity of the problem, and the hopelessness of the present state of mental health resources in combating it, have finally received the national recognition they deserve.

To be sure, recognition is only a first step, and now we must prepare ourselves for the long uphill struggle, the tedious evolution of expanding mental health resources, and the painful though necessary soul-searching of our own services and the ways they might be improved. There is one thing about which we should be fully aware: federal and state legislatures are not likely to appropriate large sums of money for an expanding mental health program without first evaluating existing services and determining to what extent they are functioning as they should.

And it is perhaps at this pivotal point in the mental health movement that we should pause to identify our objectives, and determine whether current practices are designed to achieve them.

INADEQUATE USE OF PRESENT PSYCHIATRIC RESOURCES

It is my feeling that existing community mental health programs, typically embodied in the mental health clinic, have

not been what they are supposed to be. Individuals requesting services have frequently been turned away, ignored, or indefinitely put off to the point of being frustrated and annoyed by the apparently complacent attitudes of the professional personnel involved. It is common knowledge that the majority of mental health clinics have lengthy waiting lists, with little or no hope of providing services for most of those who apply.

Contrary to the usual explanations given for these conditions, the problem is not entirely that of staff shortages. It is true that many clinics go begging for professionally trained and experienced personnel to fill positions that have in many instances been vacant for years, and are forced to offer salaries that are totally inadequate in terms of the job qualifications. Many clinics are quickly discovering that personnel are simply not available or have turned away to more lucrative jobs in industry and private practice. It is a sad but cold fact that many clinics are clinics in name only, and are actually deficient in terms of staff and services available.

Many such clinics are reduced to giving a few psychological "tests," or doing perfunctory social histories, or conducting routine psychiatric evaluations for referrals from other social agencies. As a matter of fact, these clinics have come to extend a laboratory type service to welfare agencies, juvenile courts, orphanages and public schools. By no means, however, do these clinics extend the type of service clearly identified with the concept of a mental health clinic or a guidance unit; nor do the professional personnel involved any longer seem to grasp the essential nature of their functions, the over-all mental health needs of their community, or how best to use their skills to serve those needs. While it is vital that clinics actively

pursue a policy of planning and defining their own program, they have instead acceded to the more easily defined demands of welfare, social and educational institutions.

Conditions are becoming such that it is increasingly difficult for self-referrals to obtain an appointment, while clinics find themselves rendering services primarily to those who are coerced into coming by outside agencies who define the patients' problems for them. Such referrals have only the foggiest notion as to why they are coming, and know much less about the clinic. We are confronted by the recurring experience of mothers dragging their youngsters to the clinic because they have been such a problem to the school, the parents meekly submitting to the wills of these awesome institutions controlling their lives, without any real understanding of what is actually happening.

If such a parent rebels at this treatment, she is labeled "resistant" by the clinic, and therefore not amenable to its services. This approach has the twofold advantage of reducing the load of the clinic, while ostensibly satisfying its commitments to the community.

To repeat, this situation cannot be attributed entirely to shortages in professional staff. If anything, the reverse might very well be closer to the truth, for, poor salaries notwithstanding, it seems to me that many competent and highly qualified individuals, upon observing existing conditions in the typical clinic, quite understandably turn their backs on what must appear to them as a hopeless situation.

But many clinics are blessed with a full complement of professional staff, and still have found problems no less taxing. Unable to keep pace with the mounting flow of referrals, these clinics have turned to the belief that their existing staff is inadequate

and have stepped up their demands for expansion.

Would this necessarily be the complete or best solution?

From all that we can glean from past experience, it would hardly seem so. Expansion and the increased complexity of agencies—with the inevitable divisions, departments, and sections—have a way of creating further inefficiency. While it would seem quite logical that greater demands for services should be followed by expansion of facilities, I would suggest that clinics first carefully review the demands being placed upon their services. In doing so, I believe we would quickly realize how greatly attenuated has become our concept of mental illness. It is quite possible that what passes for an increase in demands for services is largely an unwonted expansion of the definition of mental illness.

Mental health clinics, with their professionally trained and experienced staff, are rightfully entrusted with the responsibility of defining for the individual patient the nature of his problem and the means for coping with it. Instead, clinics have in many instances passively abdicated this responsibility to outside agencies, which they have allowed to define their roles and functions for them. The consequences of this have been quite inevitable.

MENTAL HEALTH CLINIC FUNCTIONS DILUTED

No clinic, however large or well-equipped, is capable of meeting the relentless flow of problems in poor school adjustment, academic failure, aggressive behavior, rebelliousness, petty theft, inattentiveness, nail-biting, or any other of a number of problems of a nuisance value to the school, but of no direct concern to the primary objective of the mental health clinic, which

is to extend care and treatment to individuals with mental and emotional disturbances. Problems of school behavior are largely the responsibility of the schools, and if permitted to do so, they would prove themselves quite capable of devising their own measures to deal with such problems.

I very much fear, however, that clinics have implicitly conveyed to schools that they, the schools, are not competent to deal with such problems, and should therefore accept the guidance of the clinic on what is best. In treating an individual patient, we would scarcely assume such responsibility for his behavior; nor would we knowingly undermine his confidence in handling his problems. Yet, we seem to exhibit this very inclination in our attitude toward the schools.

The same may be said of juvenile courts, departments of welfare or any other agency which allows itself to fall into the habit of passively depending on the clinic to make its decisions, while the clinic similarly submits to this definition of its role.

From juvenile courts come referrals of truancy, larceny, burglary, assault and battery, forgery and car theft. Beyond ascertaining the presence or absence of a mental condition which might be the cause of such behavior, and making appropriate recommendations, the clinic has no responsibility for the adjudication of such cases. However, many of them are routinely referred by the courts with the hope that the clinic will fill the void created by the absence of suitable juvenile detention and rehabilitation facilities. Again the clinic is led into accepting a responsibility which it cannot adequately discharge, and which should properly be left to the community.

While such agencies are doubtless in need of help, it is questionable that exhaustive studies of individual cases are of any

benefit. In fact, the arrival on the scene of an abstruse psychiatric and/or psychological report has a tendency to magnify emotional aspects of the problem, and thus freeze any corrective action that the court might otherwise have taken.

There remains, however, a definite area within which the clinic may function very effectively, and that is in the area of consultation. It seems to me that there are few problems which require the direct and time-consuming involvement of the clinic. Consultation, on the other hand, calls for periodic face-to-face interviews between a clinic staff member and one or more representatives from the community agency, who review each case. Probation officers, school counselors and welfare workers are accordingly helped in reaching a decision, but responsibility for decisions remains theirs and the institutions they represent. To be sure, some cases will still be referred for psychiatric services, but only after a preliminary screening process.

SOCIAL ADJUSTMENT PROBLEMS OVERRUN CLINIC

In the not too distant future, we are going to see the development of comprehensive community mental health centers which offer a broad variety of services, including: diagnosis and evaluation, emergency psychiatric units, outpatient and inpatient services, day and night care, guidance and counseling, vocational rehabilitation, consultative services to other community agencies, and mental health information and education.

In the absence of such a center, however, the psychiatric clinic is attempting to serve the mental health needs of the community either directly or through co-ordination with other agencies, while at the same time fulfilling, rather unsuccessfully, its primary function as an outpatient psychiatric clinic

or, in some instances, as a family guidance and counseling unit.

This perhaps accounts for the present popularity of the term "all-purpose clinic," a label all too often attached to the typical community mental health center. This erroneously used term has beguiled clinics into assuming broad responsibilities for which they are not adequately equipped, and has contributed to the present dilution of their functions.

It is not too surprising, therefore, to see the attitudes of despair, aimlessness, and what often passes for indifference on the part of clinic staff members, concerning their chosen work. One cannot help associating this with the disappointments and frustrations they must encounter every day as they try to measure up to a challenge that is nothing short of superhuman.

The influx of social adjustment problems has far exceeded problems of mental and emotional disturbance, and has created an enormous amount of work for the clinic. To meet the pressing needs of juvenile courts, public schools and welfare agencies, the psychiatrist finds himself spending interminable hours of psychiatric interviewing; the psychologist is burdened with a weary schedule of testing; and the social worker is faced with the task of tediously digging into the social and developmental history of the patient. Not the least of all are the many hours of staff conferences devoted to discussing cases that have been thoroughly evaluated during this withering process. It is important to note that this elaborate intake procedure is doubtless as tiring and confusing to the family being seen as it is to the staff.

And what, may we ask, are its rewards? Surely this vast expenditure of energy deserves to be scrutinized in terms of how effective it is in the over-all treatment program: Clinics usually find that the majority

of cases so exhaustively examined do not reach treatment after all, since so little staff time remains available to this end, and since many such cases turn out to be unsuitable for treatment. In any case, it appears that the evaluation process would have been more expeditiously served by shorter and more appropriate means.

I do not know what the prevailing conditions are in all clinics, but I firmly suspect that elaborate intake procedures are all too often followed blindly, with little discrimination on the part of the staff as to how much energy should be invested in a single case. Mental health clinics, however, cannot afford the luxury of indulging in exhaustive case studies, unless the need is clearly indicated. It seems to me that some initial screening process should prevail, incorporated within a flexible pre-intake program. The clinic should exert leadership in defining for itself what types of problems it will deal with, and then vigorously pursue those techniques that would most quickly and efficiently identify such cases.

The results of such a program would doubtless give the clinic greater latitude in the types of services it can offer, and I am thinking specifically of short-term counseling, which perhaps would consist of a single interview in some cases, consultative and educational services to other agencies and institutions, and the maintenance of an effective aftercare program for patients discharged from mental hospitals.

There is no question about the importance of preventive psychiatry, and clinics occupy a vital role during the germinal stage of behavior disorders. However, while most cases referred to the clinic offer outstanding opportunities for prevention, the fact is that many clinics do not offer any type of prophylactic service.

I submit that the typical clinic fires its

full salvo on the initial encounter with new referrals, leaving its resources spent and unable to follow up when needed; not to mention that its aim is misdirected in many cases. It approaches each new referral as if it were a potential treatment case, ignoring its own limitations. After committing itself in this way, it is only natural for others to become a little annoyed when it reneges on the promise it implicitly made.¹

Permit me to pause for a moment to reflect on another interesting trend, one similar to that occurring in clinics, though of a somewhat wider scope. We have observed how the outpatient clinic—designated as our second zone of defense against mental illness—has been dissipating its strength on an influx of social adjustment problems, leaving it unable to fulfill its

¹ It is acknowledged that some clinics have developed sophisticated and flexible intake procedures. These techniques usually consist of group intake interviews, during which new referrals are invited to discuss with other parents current problems concerning their children. In the process, they are helped toward discovering inappropriate techniques, common errors of misunderstanding, and possible methods of bringing about change.

Intake procedures such as these have the advantages of: (a) identifying the more severe problems, for which further psychiatric service is indicated, (b) providing early prophylactic measures against milder behavior disorders, and (c) reducing the load of cases otherwise requiring intensive evaluation. However, many clinics are lagging in this respect, clinging to techniques which are outmoded and no longer applicable. For example, such clinics might make an initial though modest beginning by adapting the above techniques to individual interviews. This would combine counseling, supportive and evaluative techniques in a single interview, achieving essentially the same goals. It has already been demonstrated in some clinics that pre-intake and group intake methods have the twofold advantage of identifying more severe problems while leaving others with the feeling of having been helped.

primary function of treating mental and emotional disturbances. We have also noted how this is partly attributed to the failure of those facilities which have been designated as our first line of defense against mental illness; namely, the educational, religious and social institutions in the community. This is no fault of these particular institutions; rather, it represents an inevitable portion of human frailty and inadequacy.

But the interesting point is that mental hospitals, our last zone of defense on the opposite end of the spectrum, are also confronted by an influx of human emotional problems which the outpatient clinic has somehow failed to intercept and treat successfully. In a sense, the mental hospital represents the accumulated failures of all other community resources; it is truly the outer fringe of society. It, too, has come to assume a role for which it was not primarily intended: *custodial care*.

PRIMACY OF PATIENT-THERAPIST RELATIONSHIPS

I have highlighted existing relationships between the mental health clinic and various social agencies within the community, and how their roles have tended to become diluted because of the lack of vigorous expression of individual objectives. I have also stressed how this disturbing tendency has beguiled clinics into accepting broad responsibilities in solving all shades of emotional, mental and social problems existing within the community, while continuing to use intensive evaluation techniques. I have also noted how the enormous work load thus created has tended to reduce the morale of clinic personnel.

It strikes me that mental health workers are in danger of losing both their sense of direction and the high ideals of humani-

tarianism that once motivated them. Their jobs have seemingly become routine and uninspiring. Nothing could be more damaging to the attainment of the objectives of their professions, for the lively spirit of enthusiasm and the sense of strong personal values are imperative guides in striving to help those with troubled lives.

It seems to me, as I look toward the future, that mental health clinics are confronted with a challenge to restore the intimate one-to-one relationship between therapist and patient. This relationship must prevail over those now existing among the impersonal agencies which frequently reduce the individual patient to something equally impersonal.

The patient-therapist relationship is inviolable and remains the keystone of all mental health efforts. I also believe that we who enter this field do so because of certain human and personal attributes which dispose us toward helping others, and it is vital to the fulfillment of these values that we maintain close personal touch with our patients. We strive for the same sense of fulfillment in those we are trying to help, and certainly we should do no less for ourselves.

I am not at all proposing that we should abandon our commitments to the community, nor am I suggesting that we encourage administrative anarchy in our clinics by excessive "rugged individualism." To be sure, there exists the danger of going too far to the opposite extreme. This would consist of ignoring the very real help we might extend to other agencies, while each of us selfishly pursues private aims, oblivious of our own shortcomings, blind to the lines of authority and supervision that would control our mistakes.

I *am* proposing, however, that we restore a more normal balance between commitment to others and commitment to our primary objectives. In this respect, clinic directors are obligated to assert leadership in helping the clinic to regain its unique identity and sense of direction.

As I mentioned in my introductory paragraphs, the mental health needs of the nation are finally receiving greater recognition. If we are to be deserving of the massive assistance programs that are in the offing, it seems to me that we must first examine ourselves and make certain that we are doing everything possible within the limitations of existing resources.

The public image of the sex offender

It is the purpose of this paper to discuss the image of the sex offender in the view of the urban middle class in American society. This image directly influences the treatment of American sex offenders and is reflected in the laws and therefore the punishments concerning them—punishments often colored by the opinions of the urban middle class and as frequently unrelated to the alleged offenses, the needs of the offender or the needs of the community.

That this is so should not be surprising, since the law is not only made by middle-class persons but also enforced and administered by them. This is largely true because the professional status required for involvement in legal procedure usually requires a higher education: that is, a college degree. This in turn is chiefly the posses-

sion of the middle- and upper-status person because such an individual is trained at home to meet the requirements needed to achieve professional standing.

"Upper-status boys learn that good, or at least adequate performance in school is necessary, that they are expected to do well enough in secondary school to get admitted to college" (9). At the same time, lower-status homes teach that college is "not for his kind" and discourage even intelligent youngsters from expecting a college education (9). The result is that lower-class persons are under-represented in all professions and in the business classes and that those lower-class persons who do attain professional or middle-class status do so only by exhibiting attitudes favorable to the middle-class point of view.

Since today education is the principal route to success in American life (22), and since only five per cent of lower-class chil-

dren ever graduate from college, there is hardly any possibility that this social class will have any more of an influence on the law in the future than in the past.

In addition, it should be understood that the enforcement of law in the United States is also related to the social position of the alleged offender. This is true because "the members of the lower class in any society are defenseless, have fewer resources and less influence than members of the middle and upper classes" (17). The police, the courts and public opinion are much hastier to arrest, condemn and punish lower-class persons than persons of the higher classes.

Particularly strong is the influence of the middle and upper classes on the media of public opinion. This is again the result of the relatively high level of education enjoyed by that social class and their consequently greater alertness to public issues and public decisions (4). Thus, a circular reaction is set in motion whereby the views of the upper strata of our society are reflected in the newspapers, magazines, radio and television, while, in turn, all strata of society are influenced by these media (2).

As a result, opinions concerning crime, including sex crimes, are so influenced and we are justified in presuming that the treatment of the accused and the convicted sex offender is directly related to the socio-economic position of the offender, the jury and the court personnel (12). As the latter status is most often urban and middle class, we contend that the views of this group concerning sex offenders are crucial influences in the treatment of such offenders.

Investigation of newspaper stories concerning sex crimes reveal not only a considerable amount of ignorance concerning the nature of such crimes and criminals, but also indicate some specific attitudes

toward sex generally. Extreme headlines concerning sex crimes refer to "sex maniacs," "fiends," "degenerates" and "sex crime waves" (13).

Such terminology implies that sex criminals are completely different from all other people in that they have an exceptional and unusual sex urge, that they are unwilling to control their monumental sex appetites and that the community is about to be overwhelmed by these "monsters" unless drastic protective measures are taken at once. Tough laws and vengeful punishments are advocated (13), particularly because sex criminals are believed to be far more dangerous than other criminals (20).

This kind of hysteria, however, is not only related to criminal acts. It undoubtedly is also related to the general sex attitudes prevalent in American culture. Thus, there is the influence of the social visibility of the sex offender and the sex offense. For instance, masturbation may be considered a private evil, but unmarried motherhood a public offense (18). The status and role of persons involved in a sex act also bear on the public attitude concerning it. Aggressive females or submissive males are viewed as "unnatural," while lower-class sex behavior is generally considered immoral by the middle and upper class, who view themselves as the guardians of morality.

Women may use sex as a means to an end, such as marriage, but for men, it is commonly believed, sex should be an end in itself. Therefore, women involved in sexuality are seen as the victims of aggressive men who are expected to seek lower-class not middle-class women as the objects of such aggression (18).

Finally, the degree of deviation of any sex act from coitus in marriage is used as a criterion of "normal" and "abnormal" by

the law. Many of these laws do not even spell out the forbidden acts but merely mention "crimes against nature" (23).

All of this ignores that culture, that is the man-made environment, determines sexual behavior just as it determines all behavior. No sex act is either normal or abnormal except by the circumstances of learned, cultural definition. As Lovell Bixby, head of corrections for New Jersey, has said: ". . . sex acts may be illegal, but not therefore abnormal" (15c).

Attitudes and fears concerning sex are learned in the reference group of subcultures as well and differ from time to time and from place to place in the same fashion as any other aspects of the human culture. In fact, "different societies do differ more in their attitudes toward sex than in any other activity within the field of ethics," a fact usually overlooked by those who wish to make "morals" and "sex behavior" equivalent (7).

Just as sex attitudes differ between widely separated societies, they also differ between social classes. The norms, or behavior expectations which dictate the actions of group members, include, of course, his sexual actions, since every member of a group, every human living with others, is expected to comply with those norms which define his status-role (19).

If this status-role involves a generally aggressive behavior, a very forceful environment and a great deal of biological enjoyment, then individuals who live in such an environment will express themselves sexually in as aggressive a manner as their group permits. This behavior, however, is viewed with disapproval by other groups who ordinarily live a less violent life (9).

Consequently, a good deal of "sex criminality" and "sex deviation" is perfectly normal in the situation in which it occurs but is judged as "criminal" in the

situation in which it is adjudicated. This is particularly true when hysterical reports treat a "sex crime" in a manner utterly foreign to the conditions prevalent in the original instance. Such hysterical reports lead many communities to treat offenses involving sex in a much harsher and vindictive manner than offenses are usually treated. Even cases of juvenile delinquency are individualized and specialized with reference to revenge when sex crimes are attributed to the young offender (6).

Such attitudes are further reinforced by statements published in newspapers. Thus, a typical letter to the editor of the *New York Times* refers to sex offenders as "fiendish sex criminals" and asks "by what rule of logic are known sex offenders permitted to roam the streets and other public places?" (15m).

In 1959 a Philadelphia grand jury deplored the so-called "leniency by the courts toward sex offenders" who were described as "sex maniacs" and who were said to "roam our streets freely." The jury called light sentences for sex criminals "a crime in itself" and denounced the legal processes which protect persons accused of sex crime (15h).

This view of sex criminals lumps all sex criminals into one category and overlooks that at certain ages and stages of human development every kind of sex expression is normal even if it does not remain so at a later stage of development (6). It would be better to distinguish between harmless sex deviations and aggressive ones and to judge sex behavior in the framework of the developmental maturity of the offender than attempt to use condemnation and hostility as remedial measures.

Letters to the editors of newspapers are not the only sources of exaggeration and hysteria concerning the image of the sex offender. Articles in learned journals

often use such phrases as "sex fiends" (10) and J. Edgar Hoover, the director of the Federal Bureau of Investigation, referred to "Peeping Toms" as a "sadistic menace" (15i).

The origin, as well as the consequences of these beliefs is the oft-promoted opinion that victims of sex attacks are "ruined for life" (21). This may very well be true in a culture which has created a hysterical atmosphere concerning sex crimes particularly and sex generally. Fear leads to traumatic experiences and the fears surrounding sex crimes are so great that the victims are indeed ruined by the slander, gossip and punitive attitude of their relatives and friends (21). It is therefore not the sex crime per se which ruins the victim but the cultural definition surrounding the actors in the situation which contribute to the "ruin." As a consequence of these attitudes we cannot rely on the statistics concerning rape or other crimes because many victims do not complain for fear of embarrassment.

For example, on September 14, 1962, a 12-year-old girl was raped and stabbed to death in a New York City apartment house. Tenants of the apartment house claimed that at least 30 rapes had occurred there in recent months but were not reported (15u). In addition, there is good reason to believe that many rape victims precipitate such assault just as many murder victims promote their own murder (1).

A comparison of the homicide rates in 28 American cities with the rape rates in the same cities strikingly illustrates the unreliability of the rape statistics. Previous investigation has shown that homicide rates are much higher in southern cities than in centrally located U. S. cities, while New England exhibits the lowest homicide rates in the country. This phenomenon is closely related to a negative

correlation between status and homicide (5) and should also hold true for other physical assault, particularly rape, because both are crimes against the person. Since no such pattern is evident for rape we must conclude that the statistics are unreliable by reason of the poor reporting indicated.

A comparison of rape and homicide rates in 28 American cities for 1962

City	Population*	Population index†	Homicide-population ratio‡	Rape-population ratio§
Atlanta	500,000	46.9	205.5	92.5
Richmond	218,000	20.5	197.1	72.2
Dallas	710,000	66.7	178.1	65.1
New Orleans	635,000	59.6	154.9	74.3
Miami	296,000	27.8	153.6	43.2
Washington	755,000	71.0	147.8	53.2
Baltimore	936,000	87.9	136.5	56.2
Houston	970,000	91.1	134.2	112.0
Chicago	3,540,000	332.4	133.9	225.0
St. Louis	730,000	68.5	116.2	186.9
Oklahoma City	345,000	32.4	103.1	55.6
Boston	680,000	63.8	101.3	75.2
Detroit	1,645,000	154.5	97.8	99.5
San Francisco	745,000	70.0	87.3	89.0
Cleveland	870,000	81.7	86.2	29.4
New York	7,775,000	730.0	80.1	55.6
Los Angeles	2,565,000	240.8	76.6	187.0
Philadelphia	1,995,000	187.3	76.3	128.8
Portland, Oreg.	371,000	34.8	76.1	49.1
Jersey City	273,000	25.6	72.3	25.4
Pittsburgh	595,000	55.9	64.0	71.1
Seattle	559,000	52.5	63.6	69.5
Memphis	658,000	61.8	61.7	28.3
Honolulu	306,000	28.7	60.3	17.8
Omaha	320,000	30.0	53.7	35.3
Buffalo	525,000	49.3	44.4	22.5
Minneapolis	480,000	45.1	35.6	38.8
Milwaukee	750,000	70.4	27.8	21.6

* Total Population, 30,747,000.

† Mean, 1,098,000=100.

‡ Total Homicides, 2,427. Mean, 86.7=100.

§ Total Rapes, 6,067. Mean, 216.7=100.

Note: Homicide and rape figures taken from the F.B.I. Crime Report of March 31, 1963. Population figures taken from Rand-McNally Atlas, 1962.

Thus, the above table indicates that while Atlanta has a population only 47 per cent as great as the average mean population of the listed cities, it has a homicide rate exceeding expectations by more than 105 per cent and a rape rate only 93 per cent of what we might expect. At the same time Los Angeles exhibits only 77 per cent of expected homicides but exceeds the expected rate of rape by 87 per cent.

The unreliability of sex crimes statistics is even further accented by the observation that many so-called sex crimes never occurred at all. Often these sex crimes are the products of the imagination of women and children who accuse innocent men. Relying on the usual hysteria surrounding such accusations, such women and children have succeeded in obtaining convictions of the innocent. Often such stories are believed by the women and children who tell them because they have repeated them so often under prolonged questioning (8). Since there is usually no evidence except the testimony of the alleged victim, many men are convicted purely on such uncorroborated testimony. Complaints of this nature are often unfounded and many men have been "railroaded" on sex offense charges by disturbed children and spiteful women (16).

Many Americans believe that there are tens of thousands of homicidal sex fiends roaming through the country; that these sex offenders are usually recidivists; that minor sex offenders progress to more serious crimes later; that it is possible to predict the danger of serious crimes being committed by sex deviates; that sex deviation is a clinical entity; that effective treatment methods are known and can be used; that the law gets at the brutal and vicious sex criminal and finally that the sex crime problem can be "solved" by passing more

laws (11). Not one of these beliefs is supported by the evidence. On the contrary, the late Dr. Alfred Kinsey remarked that "we find that there is no evidence for an increase or decrease of the rate of sex crimes in the last 50 years" (15f). Homicide associated with such cases is most unusual. In fact, nine out of ten cases of homicide occur within the circle of friends and family and this is even more true of female victims than of male victims. Thus, the chance of murder by close friends or relatives is far greater than the chance of murder by a "sex fiend" (5).

Only murderers have a lower rate of recidivism than sex offenders (20) and those who do repeat their offense usually are convicted for minor deviations such as "exhibitionism" or "peeping."

Most sex offenders are mild and submissive and it is impossible to predict their future actions. For this reason laws which are designed to restrain sex deviants in advance cannot be justly applied. Therefore, the commitment of minor sex offenders to mental hospitals without due process of law is "founded on a technical legalism of the most vicious sort" (11).

In fact, there is a good deal of evidence that present laws pertaining to sex offenses cannot be enforced because sexual conduct is private, because cultural conditions do not pertain to the intent of the law, and because the apprehension and conviction of offenders is uncertain and differentially enforced.

The privacy of sexual behavior not only insures difficulty in enforcing laws pertaining to sex offenses but also promotes a situation which makes accusations easy to make and hard to prove (15a).

It is for these reasons that Austria recently changed its laws pertaining to homosexuality, abolishing penalties for such be-

havior on the grounds that activities between consenting adults are not the proper province for legal interference (3).

A similar recommendation was made by the British Committee on Homosexual Offenses and Prostitution, commonly known as the Wolfenden Commission. This committee concluded that consensual adult homosexuality should not be a statutory offense (3).

While Parliament did not accept these recommendations, the Archbishop of Canterbury, Dr. Geoffrey Fisher, praised the Wolfenden Report, mainly for distinguishing private "sin" from public "crime" (15n), a view in which the Roman Catholic spokesman on the issue concurred (15j), and which was endorsed by the Assembly of the Church of England (15k).

A good example of the change in cultural conditions which make some of the laws pertaining to sex offenses obsolete are the ages applied to statutory rape. In view of the spread of sexual knowledge among young people today "statutory" rape ages are hardly realistic (16). Instead of relying on such unenforceable laws to protect young women it would be better to instruct all junior and senior high school students in human reproduction and sex.

Judge Morris Ploscowe estimated that if all sex offenders were ever jailed, then only 5 per cent of the population would have to support the 95 per cent in prison. Thus we see that the law makes most adolescent and adult males and many females potential sex criminals.

From time to time certain phenomena in our culture become the "whipping boys" for sex crimes. Thus, a good number of people believe, as does F.B.I. director J. Edgar Hoover, that so-called obscene literature is responsible for sex crimes (15g). The same view was expressed by the late

Senator Estes Kefauver, who claimed that the sale of about \$500 million worth of pornographic literature since 1940 "caused the doubling of sex crimes" (15h). It is interesting to contemplate why pornographic material is believed to have such a great motivational force, while nonpornographic literature is not credited with similar powers.

Teachers have often been singled out as dangerous child molesters. Testifying to the House Appropriations Subcommittee in January of 1962, Mr. Hoover advocated the fingerprinting of all teachers as potentially dangerous and supported his stand by citing one instance of such molestation by one teacher (15s).

A similar attitude was revealed by state Assemblyman McCloskey of Levittown, N. Y., who introduced a bill into the state legislature requiring all school bus drivers to be fingerprinted because of alleged molestation of two girl children (15e). The inference we can draw from these proposals is that sex crimes are believed to be the consequence of opportunity rather than emotional condition and that all teachers and all school bus drivers have identical sexual interests because they deal with children in their occupation.

Another cultural phenomenon affecting the public view of the sex offender is the over-representation of Negroes in the category of "rapists" (23). This problem has traditionally been severe in the South where the "rape complex" has been used to oppose any attempt of Negroes to rise socially. The converse of this belief is the "women on a pedestal" pattern found in most of western civilization, but particularly in the American South, where it is used by white males as a compensation for their sexual activities with Negro women (14).

Sex offenses are also produced by segments of the social structure or by special circumstances. Thus, prisons promote homosexuality while incest is most common in rural areas. Prostitution is frequent in lumbering towns where the sex ratio is high (23). All of this indicates that sex crimes are not "crimes against nature" but the outgrowth of conditions in the social world. Sex needs are met in any way available. Therefore, the availability of sexual outlets determine sexual conduct as much as conduct produces availability.

Although the foregoing represents the dominant American attitudes toward sex crimes, a change in these attitudes is also in evidence at this time.

One example of this change is the relationship of the courts to Negro sex criminals. Thus, on April 23, 1962, the Mississippi Supreme Court overturned the conviction for rape of a 20-year-old Negro, George Gordon, because no Negroes had been called for jury duty in his case. This was done even though Gordon had admitted the attack and had already been sentenced to death (15r).

In February of 1962, the Georgia Pardon and Parole Board, for the first time in the history of that state, commuted the death sentence of two Negroes who had been convicted of raping a white woman and who had already lost appeals to the Georgia Supreme Court (15q).

In 1961 the Yazoo County grand jury in Mississippi indicted three white men for raping a Negro woman. They pleaded guilty and were given life imprisonment (15p).

These and many other instances indicate a greater concern for the rights of Negroes in the South, both as defendants and as victims in sex attack cases.

Further changes in attitude concerning

sex criminals are evidenced by the recommendations for treatment and psychiatric help for offenders by grand juries, judges, correctional officers and media of communication. While such recommendations are still relatively rare, one example is the New Jersey Sex Offender Law passed in 1949. This law lists the major sex offenses and requires treatment for those convicted, either in psychiatric institutions, correctional institutions or on probation (15b).

In Bergen County, N. J., the grand jury recently called for more institutions for "those unfortunates who suffer from sex disorders" (15o), while in New York, Kings County Judge Samuel Leibowitz asked the legislature for an institution for the exclusive treatment of sex offenders as far back as 1958. In sentencing an 18-year-old child molester, the judge remarked "the defendant is not a criminal and is not insane. He is a sex psychopath and I have no place to send him but jail. He needs treatment in a special institution" (15i).

In 1955, Brooklyn, N. Y., inaugurated a program whereby sex offenders who admit their guilt would receive psychiatric treatment while on probation. The offenders pay for this treatment themselves (15d).

In July of 1962 a New York City radio station, WBAI-FM, made news by permitting eight homosexual males to discuss their problems on the radio in a one-and-one-half hour program (15t).

All of these developments indicate the gradual realization by professionals and others that sex expression is not "abnormal" by reason of inborn instinct, inherited depravity or atavistic development, but rather by standards of culture and emotional expectation. Many sex deviations are remnants of normal childhood sexuality perpetuated into adulthood. A lack of understanding of this important truth often leads parents to fear that their

children are sex perverts, just as public opinion is led to believe the same of adult sex offenders.

It is to be hoped that this new trend in understanding the sex offender will continue until treatment is substituted for punishment and unrealistic laws are repealed. All of this must, of course, await the day when sex itself is no longer regarded with fear and hysteria but with the kind of understanding which all of us deserve from each other.

SUMMARY AND CONCLUSIONS

We have seen that attitudes concerning sex offenders are determined by the urban middle class; that these attitudes are heavily influenced by the media of mass communication; that an air of fear and hysteria surrounds sex in America; that the extent of sex criminality is greatly exaggerated; that the laws pertaining to sex crimes cannot be enforced and that a gradual change from punitive to ameliorative attitudes toward sex criminals is now in evidence in this country.

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FELIX COHEN, M.D.

Alcoholics Anonymous principles and the treatment of emotional illness

SUCCESS OF AA WITH ALCOHOLIC PATIENTS

A wide measure of agreement exists among medical, lay and various professional groups that Alcoholics Anonymous has had significant success with large numbers of cases of severe alcoholism.

Following an intensive survey the recent definitive report *Community Resources in Mental Health* stated: "We were impressed with what we were told of the [AA] program" . . . "Other community contacts revealed that the clergy, doctors, and law enforcement officers consider AA a useful resource for help to the alcoholic" (8). Similarly, Jellinek recently noted that the "respect and admiration to which Alcoholics Anonymous have a claim on account of their great achievements" (6). Hirsh has stated: "Alcoholics Anonymous is one of the most far-reaching organizations of its kind and one of the most potent educa-

tional rehabilitation and control forces in the alcoholism field" (5).

Many people are acquainted with striking examples of the rehabilitation of individual cases of severe chronic alcoholism by means of this program. Even those who are critical of AA on various scores confirm the empirical fact of the success achieved. Further recognition of the value of AA is evident in the fact that hospitals, clinics, prisons and large industrial corporations welcome and sponsor the formation of Alcoholics Anonymous groups within their own settings.

The potential value for broader psychiatric use of a program like Alcoholics

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Anonymous was first suggested to this writer by certain clinical experiences. The first of these was an unexpected outcome observed in a patient while the writer was a staff physician in a veterans psychiatric hospital.

This patient was borderline schizophrenic as well as chronically alcoholic. A leave of absence from the hospital had been granted with some misgivings since during previous visits home, the patient had drunk to excess, had been abusive to his wife, and had behaved in an alarming and threatening fashion, necessitating premature return to the hospital. However, in his last visit, the patient did not resume his previous unacceptable behavior and was able to remain at home.

After a full year of trial visit had elapsed, the patient voluntarily visited the hospital and presented a most favorable appearance. He attributed his success to his participation in the Alcoholics Anonymous program which he had joined in the second week of his leave. He had become extremely active in this program and had remained sober for this entire period. His relationship with his wife had become amicable and he had found satisfaction in regular work once again. The patient was quite neatly dressed; he was alert, pleasant, friendly, outgoing, responsive to the interview situation and quite lacking in any psychotic ideation. His participation in the Alcoholics Anonymous program had apparently been of general mental health benefit to him. His appearance and conduct during the interview were much more favorable than would have been expected merely on the basis of sobriety during this period.

Of course, this single case only provided suggestive evidence that the AA program could go beyond sobriety in its effects upon personality. However, it led the writer to attempt an evaluation of the effects of

the Alcoholics Anonymous program. This effort included a review of the literature, direct observation of 15 AA meetings, and detailed case histories of 50 AA members who had achieved sobriety for at least one year. A substantial accumulation of observations about AA members and their program was gathered by this means (3).

Of particular interest is the fact that a significant proportion of the interviewees in this case series revealed evidence of psychiatric problems antedating as well as accompanying the period of active alcoholism. These symptoms were indistinguishable from those manifested by non-alcoholic emotionally ill persons and included a wide range of depressive states, compulsions—such as overeating—anxieties, and other neurotic tensions, and borderline schizophrenic or frankly psychotic states as well.

The writer's impression was that these interviewees manifested a marked diminution of their long-standing neurotic and/or psychotic symptoms following their participation in the AA program. Some were currently enjoying a more advanced level of emotional stability and well-being than ever before. These latter effects were in addition to the attainment of sobriety and the amelioration of the destructive psychosocial effects of years of active alcoholism.

Thus, the previous impression obtained in the single case was further supported by a more extensive and comprehensive study of AA members. Accordingly, it seems reasonable to infer that the AA program contains features which may produce a number of mental health benefits apart from and beyond the achievement of sobriety.

However, the presence and significance of these additional mental health effects of the AA program have been insufficiently

noted in the past, partly because of the diversion of attention to the dramatic achievement of sobriety. In view of this state of affairs, the purpose of this paper is to describe and analyze the procedures and content of the AA program and to consider their relevance to general mental health effects.

THE AA PROGRAM

Alcoholics Anonymous constitutes an informal fellowship founded in 1934 and numbering at the present time in excess of 250,000 persons whose alcoholism has been arrested. These members meet in groups, usually including between 20 and 100 individuals, to express and discuss the principles of their program—"The Twelve Steps of AA"—as exemplified in their own lives. Their purpose is to achieve and maintain sobriety for themselves and to provide a setting for helping "sick" alcoholics to do so as well. The assumption is that the achievement of sobriety for the compulsive drinker can only be accomplished through certain fundamental changes in his attitude and relationships as indicated in the "Twelve Steps."

The Alcoholics Anonymous program consists essentially of the elaboration and implementation of these "Twelve Steps," which are:

1—We admitted we were powerless over alcohol—that our lives had become unmanageable.

2—Came to believe that a Power greater than ourselves could restore us to sanity.

3—Made a decision to turn our will and our lives over to the care of God as we understood Him.

4—Made a searching and fearless moral inventory of ourselves.

5—Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6—Were entirely ready to have God remove all these defects of character.

7—Humbly asked Him to remove our shortcomings.

8—Made a list of all persons we had harmed, and became willing to make amends to them all.

9—Made direct amends to such people wherever possible, except when to do so would injure them or others.

10—Continued to take personal inventory and when we were wrong, promptly admitted it.

11—Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12—Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs (9).

RESPONSES TO THE AA

It is noteworthy that alcoholism is referred to directly in only one of these statements. That is, the alcoholic is asked to confront and to accept the fact of his powerlessness to conquer his addiction solely by means of his own determination. Instead, these statements are concerned with the following four behavioral goals.

1. A receptive-dependent, trustful relation to a self-defined "Higher Power."

2. A willingness to confront displeasurable feelings and to review past experiences, even though this is a painful process.

3. The development of interpersonal relationships of goodwill and co-operation with peers.

4. A nurturant-supportive-relationship of helping others to overcome their alcoholic addiction.

These receptive-dependent, peer, and nurturant-supportive relationships are fundamental and familiar goals for behavior, expressed in family, educational, religious and general cultural sources. To

relinquish long-standing dispositions and to modify one's behavior in conformity with such goals is quite difficult in adult life.

Therefore it is noteworthy that most of the 50 participants in the case series responded to the AA program by showing certain changes consistent with one or more of these attitude goals. A detailed consideration of the means by which such personality changes are effected in the AA program would be beyond the scope of the present paper. However, the principal technical features may be briefly highlighted.

1. As a general rule, AA groups give scant attention to disinterested members or unresponsive alcoholics. The latter soon drop away from the meetings leaving only those who are willing and prepared to apply considerable time and effort to the program. Thus, the meetings are usually attended by a self-screened group of highly motivated participants.

2. The exclusion of professional supervision at these AA group meetings also plays a significant motivational role. In this way the members who are present are confronted with an unusual responsibility for themselves and a challenge to assume a protective role toward other persons; namely, "sick" alcoholics.

3. Despite variation in minor details, the number of different patterns of personal histories presented at AA meetings is limited. Accordingly, new members soon hear life stories which resemble their own histories. This experience frequently produces a convincing identification with these speakers who have achieved sobriety.

4. In addition to providing opportunities for individual identification, these well-attended group meetings are a potent vehicle for evoking in the members a sense of group belongingness.

The childhood conception of the family and/or the adult image of society may be symbolized by the group because of its substantial size and its common goals. Once the member experiences acceptance in the AA group, he seeks to preserve this relationship by conforming to the group norms of attitude and behavior. Therefore, the understanding, support and acceptance obtained from the group by the participant are potent influences for attitude and behavior change. An excellent and more extensive discussion of the changing of attitudes by these group forces has been provided by Frank (4).

5. The usual pattern for new members is to attend two to seven meetings a week, each featuring several speakers and much informal discussion. Meantime the themes of the "Twelve Steps" are repeated with great frequency, accompanied by numerous testimonials and illustrations which are hypnotically suggestive in their impact. Thus, the group meetings provide effective media for influencing participants because of the number and variety of possible models for individual identification, the sense of group belongingness created, and the accepting attitude to the AA principles induced among new members.

APPLICABILITY TO GENERAL PSYCHIATRIC PROBLEMS

It will be recalled that a majority of these cases in the above-mentioned series had shown evidence of psychiatric problems prior to onset of alcoholism. Following their participation in the AA program, anxiety and/or depression were diminished or relieved, and distortions in perceptions and expectations in regard to other people were favorably modified.

The result was the diminution of earlier symptomatology, a gain in a sense of well-being, tranquillity and stability of mood,

and an enhanced capacity for realism and purposefulness in behavior. The diminution reported in neurotic and/or psychotic symptoms (in addition to the attainment of sobriety) is accordingly associated with, or may well be attributable to, the changes in their self-awareness, receptive-dependent, peer and/or nurturant-supportive relationships.

In view of the foregoing, the desirability of including the goals and procedures of the AA program in treatment of psychiatric disturbances becomes apparent. An examination of the relationships usually present in emotionally ill persons also gives support to this approach. Emotionally disturbed individuals frequently manifest a distorted view of themselves, are unstable and dependent in their peer relationships, and are usually too preoccupied with their own needs to be concerned with the needs of others. The neurotic and psychotic are usually defective in the very psychosocial relationships which are favorably modified by the AA principles. Hence, the validity of utilizing these principles with the nonalcoholic emotionally ill is further evident on the basis of present knowledge of this latter group.

How may AA principles and procedures be incorporated into a psychiatric treatment program? A preliminary attempt to establish the relative mental health importance of the several features of the AA program, using data obtained in the above-mentioned case series, showed that no single component was responsible for the general mental health effects observed (2).

It was clear that future studies of this issue should be based upon current and ongoing observations rather than retrospective case studies. Accordingly, the approach being employed in treatment at

the Cambridge Day Center, a psychiatric day hospital, is to include the entire range of AA principles and procedures where feasible, rather than to emphasize any individual element from that program.

It is of some interest and relevance to the present thesis to note that in the meantime a variety of self-help groups based upon AA principles has developed without professional initiative or direction. These are concerned principally with such addictive and impulse personality disorders as drug addiction, gambling and obesity. The extension of AA principles to these disorders is natural enough in view of their similarity to alcoholism, both in regard to certain personality features and in their well-known resistance to other forms of treatment, including psychotherapy.

The extension of these attempts to neurotic and psychotic individuals has been on a more limited scale. Former mental hospital patients have organized a number of such groups in the Middle West and the Far West (1). A somewhat related effort can be seen in Recovery Inc. (7). The nature of the symptomatology of the neurotic, and particularly the psychotic, is however often incompatible with the group processes required in the AA program. Furthermore the total exclusion of medical and professional supervision is a handicap for these patients whose very illness precludes an initial capacity for self-help.

In view of these two problems, the present approach at the Cambridge Day Center is, for example, to replace extemporaneous speaking with reading and discussion of pertinent prepared statements. Also the self-help concept is implemented in various ways, although professional supervision is maintained. A more detailed description of these procedures is being prepared for a subsequent report.

SUMMARY

The Alcoholics Anonymous program has been accepted widely as empirically successful in the treatment of chronic alcoholism. This paper presents the hypothesis that nonalcoholic emotionally ill persons can also be benefited significantly by a program based upon the principles of Alcoholics Anonymous. Support for this notion was noted on empirical evidence gathered from an exploratory retrospective case series of 50 members of Alcoholics Anonymous.

Furthermore this hypothesis is considered plausible in the light of an analysis of the AA principles as contained in the well-known "Twelve Steps" of Alcoholics Anonymous. These affirm certain goals for inwardly directed attitudes in addition to outwardly directed relationships of a receptive-dependent, peer, as well as nurturant-supportive nature. Amelioration of emotional illness may well be anticipated among individuals whose attitudes and psychosocial relationships are, in fact, significantly altered according to these goals. This expectation may be the intuitive basis for the recent development of self-help groups among individuals with psychological problems.

On the basis of the foregoing analysis, it appears feasible to include AA goals and procedures in a psychiatric treatment program for a broad range of behavior disorders. An exploratory program of this nature is presently being conducted at the

Cambridge Day Center, a psychiatric day hospital, and will be the subject of a subsequent report.

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Is there inner strength for mental troubles?

This article explores in an amateur but reverential spirit the question of whether we can have access to power and strength beyond what we normally make use of from our own usual and obvious resources.

Inevitably, one has to start with some assumption, however tentative. And that made here derives in part from personal experience and in part from a scrutiny of the experience of others.¹ This is less a personal confession than an effort to look searchingly in directions and for responses that may be relevant to the mental troubles of many. Also, I purposely refrain from an attempt to be analytical about specific sources of mental distress, whether organic, (that is, physiological), or, so to say, purely functional or mental, if such a distinction may be valid. I say this because some individuals may have organic troubles which seem beyond any efforts of the sufferer to mitigate. I am, of course, also aware that there are mental disturbances, the causes

of which are wholly or in part forgotten, deeply unconscious or just below the threshold of consciousness. And I realize that the conscious confronting of such negative influences would usually be a prior condition of the personal desire to become possessed of a feeling of reinforced self-confidence.

My major premise is that for each individual the world is his own self (and other selves) and some Other in the universe which can relate itself to man in what for him can be an identifiable and conscious experience of the otherness which permeates life and nature.

There are two observations to be made

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¹ See, for example, the now classic volume by William James, *The Varieties of Religious Experience* (New York: New American Library).

about this assumption. One has to do with vocabulary. I use deliberately the rather neutral word "Other," which recognizes at once that every religion has its own words for what in essence connotes what may approximate the same reality. We all know such other words as the Creator, God the Father, the All-Embracing, Allah, the Essential Being, the First Cause, etc. And I am convinced that be one Protestant, Catholic, Jew, Muslim, Hindu or Buddhist, the same quality of response to the Other may become a present and determinative reality.

My second observation is that if my major premise is one that you at once would deny, you can at least hear me through and ponder whether it might conceivably come to have an operational meaning for you to the point where in your aloneness you might even try to see if you might have *something* helpful disclosed to you. Receptiveness to some new kind of experience may well be a remedial asset.

What then might those be looking for who in varying degrees are aware of their own mental troubles?

Most of us could well approach life with greater courage, assurance, confidence in our own efforts, and a will to empty our minds, to some extent, of anxiety, worry, self-centeredness, negative reactions and self-pity for our sufferings. Indeed, there are many, again in diverse vocabularies, who might desire to achieve a deeper hope that in some sense "underneath are the everlasting Arms" and even that in "Thy will is my peace." Using the Freudian vocabulary, how can the "oceanic feeling" surge in upon us to our own good?

The next question then is: how can one's

approach to living incorporate the more positive and productive qualities to the end of minimizing or eliminating one's handicapping affliction, and drawing upon some power other than ourselves which makes for righteousness and health, if appropriately approached?

I declare for no one method or technique of working toward approaches and relationships with the Other, and toward a clear-headed and determined attack on one's personal problems. They have been many throughout history and no doubt all have efficacy in varying circumstances for various temperaments.

My own offering here is only suggestive and somewhat personal. It being spring as I write this, come out *by yourself* into the open air before breakfast; breathe deeply; take in the warmth of the sun, the briskness of the westerly breeze, the busy birds newly come and singing as they search for worms.² Then, ask yourself if *beyond yourself* you do not look out upon a world reflecting beauty, orderliness, lawfulness in a natural way, suggesting an Other which somehow seems to permeate the scene and impart a sense of its own reality and vibrancy directly upon your heart and mind as being at once in you and out there. The morning is possessed of something good which is conveyed from out there. And you return to the dining room for breakfast refreshed, renewed, heartened for the day. And you gladly greet those assembled with genuine warmth and good fellowship.

Perhaps as more spring days come you may experience some more abiding creative response of sustained assurance. You may well come to feel more buoyant and yeasaying than before. You may be able mysteriously to draw upon a deeper level of courage and reduce your anxiety. You may come to recognize that you are possessed

² The same attitude and approach to the world of nature can be realized even in an urban setting at every season of the year.

by a total feeling which transcends your present self.

A different approach may be sketched, however strange to one's earlier experience it may seem at first blush.

Suppose upon arising in your privacy you at once get down on your knees beside your bed and try to formulate silently something like the following which might be directive to your mind and spirit as you rise to face the day. If words fail to come, just be quiet for a few moments in a mood of accepting what may offer in the silence of being alone.

One might thus come to be able to articulate some personal expression in the following way, for example: "Oh great Other, I come seeking to know what I should do to lessen pain and anxiety, and to gain courage to face the world bravely this day.

"I come seeking power and confidence within myself to make my encounter with life today yield better things."

"I would gain a listening ear to sense how I should act and how I should respond to people and to my own problems."

Now let me offer the exhibit of the prayer of a more mature, seasoned and convinced worshipper:

"Dear Lord and Father of Mankind, forgive our feverish ways; restore us to our rightful mind, in deeper reverence praise.

"You are the Will more inclusive than the human will, who seeks to impress itself upon human life. Help me to learn that will. Thy will be done. Give us wisdom and love to help disclose how we should help and be helped toward the realizing of a Kingdom of Righteousness. We believe that in efforts toward such a Kingdom we gain a more healthy and wholesome outlook which gives courage and confidence toward right decisions."

It should, however, be noted with emphasis that there are, so to speak, good and poor prayers. The prayer of this sort: "Dear God, please cure me," seems to me to be psychologically and spiritually unsound and really selfish because so completely self-centered. A prayer with a curative plea seems to me to require a phrasing along such lines as the following: "Dear God: As I try to cope with my afflictions, I should know the wisest course to follow in line with the laws of nature and of God. Help me to learn what is Thy Will and Thy Wisdom as Thou wouldst have me follow and fulfill it. May I help myself in harmony with Thy Will."

Put in other words, good prayer should be Other-centered or God-centered and not self-centered.

A kindred method which may be invoked is one's occasional repetition to oneself of some quotation which one has found meaningful in a heartening direction. This can be some line or two from a poem, verses from the Bible or from an appropriate hymn. Think of the beauty, for example, in the line from one of Whittier's hymns: "The silence of eternity interpreted by love." Think of the stirring thrill in the line from *Green Pastures*, "Gangway for the Lord God Jehovah!"

I should at this point at least allude most inadequately to other than purely verbal efforts at relations to the Other. I refer to all the approaches through beauty appreciation and notably the arts, of which music may well be the most revealing as to that beyond ourselves.

I go now to another aspect of mental trouble which may cause an increase of such disturbance. The question often arises: "Why has this happened to me? What have I done to deserve this?"

The larger riddle presses itself peren-

nially upon the thought of many, both sick and well; namely, "Why does there have to be suffering; and what is it?"

Many, of course, have tended to associate serious suffering with some prior wrongdoing for which the suffering is the punishment. The notion that the sins of the father shall be visited upon the children unto the third and fourth generation is well-known, and in one sense it may speak an observable truth as applied to hereditary disease or the fall of materialistic civilizations. But it seems to me unmistakable that in the more personal sense it may well be said with assurance that it is usually impossible to establish a direct cause and effect relation between suffering and wrongdoing.

The Book of Job in the Bible is the classic statement of this problem, and the friends of Job can find no evidences of his wrongdoing to account for his boils and other afflictions. Finally, in one of the great human cries of literature, Job bravely says, "Though He slay me yet will I trust in Him." This is without doubt one of the noblest affirmations of faith in a God who if inscrutable has also to be accepted as ruler of the universe.

I have not space here to answer adequately, if anyone could, the normal human reaction, "If such irrational and incalculable suffering is caused or allowed by what you call God, he must be a brute incarnate." In most general terms, however, I believe the approach to this natural doubt loses sight of the pervasive reality of the mysterious evolutionary process in which a degree of freedom by creative growth may take what we would regard as backward, degenerative steps into strange and destructive and to us, on occasion, painful manifestations. The human conquest of many afflictions with more conquests still to come would seem to indicate a kind

of world in which human mastery may progressively allay and remove much suffering which was formerly regarded as a punishment from a perverse God in action.

Much but not all suffering does seem, in all honesty, to be inexplicable and therefore to be endured with some resignation. But certainly to use unexplained suffering as evidence of God's irrationality and cruelty would be a less than adequate or justifiable conclusion.

There are also, of course, those who find the relation of this suffering to what they may believe is their own sin and guilt. And no doubt there are cases in which this is true. This prompts several questions, of which the first is: what is sin?

Sin is usually a deliberate and willful, if not perverse or ignorant act which runs counter to the normal individual's established sense of what is right, contrary to the individual's conscience—all of which means that sinfulness will be recognized differently by different individuals and, of course, by different cultures and civilizations.

This inevitably leads to at least the mention of repentance and forgiveness. (I am intentionally not elaborating here on the related concept of atonement.) Certainly there are circumstances in which the individual comes to say "I am sorry for what I have done, and I hope not to repeat the offense. And I would make any correction or restitution which is possible as outward evidence of this repentant feeling and eagerness for forgiveness. I want to get back into the groove of good conscience and good conduct. Now I ask myself and others to forgive my guilt in the sense of accepting me again into the fold of right-doers and of friendly fellowship."

There are now a few collateral considerations which in one way or another may well throw light upon our central problem.

There may arise, for example, the ques-

tion: how much, how comprehensive, how intellectually accepted a faith in some Other is required for me to relate myself creatively toward it? The short answer here is perhaps, "the more the better." Yet I am certain that gropings toward faith of a highly tentative and quite simple sort, in which the *desire* and *intention* toward relationship become present, can embark the individual toward experiencing gradually a more convinced and comprehensive awareness regarding the Other.

There is, of course, for some the experience of what is called conversion, and it can be a process or varying degrees of suddenness or gradualness. But I am not bringing in conversion as typically relevant to my theme. Rather, I am stressing the value of the individual's awakened desire to get somewhat *outside himself* as he confronts mental difficulty. The relationship presumably sought is to a higher and more universal power and reality.

I might next point out that all this is not at odds with the benefits derivable from psychiatry and psychoanalysis. The present approach is rather a supplementary one which has its own supporting benefits. Indeed, there has been organized in recent years a scholarly Academy of Religion and Mental Health, composed of both religionists and eminent psychologists, which issues its own regular journal.

Mention should also be made of contemplation and meditation which I see the dictionary regards as synonyms. These do not signify listless passivity. Rather, they signify withdrawal into quietude with some focus consciously being sought upon what we may call a theme or idea or emotional state which gropes toward a reaction or feeling which might bring some illumination or reinforcement to one's total outlook and might, indeed, yield as an outcome some greater serenity and confidence for

life's encounter. All this, of course, with some practice can be made to be a valuable contributory factor in reducing the tensions of mental trouble. At certain points all this may be kindred to prayer—even if less formalized.

I hope I have said enough so that I will not be accused of a Couéism that reiterates "Every day in every way I am getting better and better." Nor does this imply uncritical acceptance of a bland "peace of mind." The process that concerns me also has no relation to miracles, although the highly sensitized individual may well approach experiences which may be truly called mystical. Finally, there is no suggestion of any technique of specious self-hypnosis.

In conclusion, what does this presentation add up to in its meaning for us all?

My answer is that I have been trying to affirm that in a variety of ways it seems possible for many individuals to help themselves toward a lessening of tensions by seeking to become related with some Other in the universe who we have a right to believe is receptive to our advances. Indeed, it may become possible for some sensitized persons to have such overtures eventually extend over into explicit worship, into a reverential experience of the Holy animating the world and in Whom in a real sense we may be said to live and move and have our being.

One classic expression of this hope and faith is in the words of St. Augustine who said, "Thou hast made us for Thyself and our hearts are restless till they find their rest in Thee."

This may seem to many to be too difficult and "transcendent" a faith to accept and voice. But I find myself wondering if it does not come close to articulating an ultimate experience of faith which could be of great helpfulness as we face life and trouble.

All this, I say, is independent of one's verbal doctrine and creed and is not conditional upon them. My own name for it, if it needs a name, is that it is a naturalistic theism.

In short, there can be inner help if the individual has the desire, the persistent intention and the cultivated sensitivity to get help from the Source of all health and strength.

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An evaluation of the effectiveness of a mental hygiene video presentation on adjustment

PROBLEM

In recent years mental hygiene practitioners have devoted increasing time and effort to preventive mental health programs (1). The primary approach has been to deal, on a community-wide basis, with the social and environmental factors which are thought to contribute to social-psychological breakdown. This approach presupposes that among the significant events which determine the mental health of an individual are those relating to his emotional milieu as well as those relating to his particular personality structure.

Within the military, mental hygienists provide consultation, (3), education and orientation to commanders in an effort to cope with the management of problem trainees, the influence of the group upon the individual, and the effect of local policy upon military members. An ad-

ditional phase of such preventive programs in military and civilian communities has been the use of lectures, orientation talks, and other media of mass communication

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that are designed to instill knowledge of mental health principles and to influence attitudes and behavior.

The literature on mental health education has recently been reviewed (4). Although mental health films are used very widely, the evaluation of their effectiveness appears to be a markedly neglected area of research. Gottheil (2) presented a lecture and film on adjustment to military life to a group of army trainees. An examination of the dysfunction rates, such as AWOL, courts-martial, and company punishments revealed no differences between the units who saw the film and control units who did not. The primary purpose of the present study is to evaluate the effect of a kin-scoped mental hygiene presentation on the adjustment of military trainees during basic training. It was reasoned that if the video presentation was successful in assisting trainees to adjust to military life by allaying fear and apprehension concerning basic training, then their improved adjustment should be reflected in improved performance in basic training. Since objective measures of performance are available, this is an ideal situation for testing the relationship between a mental hygiene presentation and adjustment.

METHOD

A 15-minute lecture entitled "Adjustment to Military Life" and a 32-minute Army film entitled "It's Up To You" were videotaped and presented via closed circuit television to three randomly selected basic training companies from one basic training regiment during their first week of training. Each of the companies consisted of approximately 250 trainees. Three companies were selected at random from the same regiment and served as controls.

The initial 15-minute lecture was aimed

at familiarizing the trainees with the effects of basic training and assuring them that the emotional manifestations of this period had been effectively handled by most trainees in the past. It was indicated that despite individual adjustment problems, all were expected to complete their basic training successfully. The 32-minute film consisted of a presentation of three trainees in basic training. The ways in which they handled their emotional reactions to basic training were illustrated. In each case the trainee received assistance from others within the military organization and eventually completed training with increased self-assurance.

During the first week of basic training, immediately after the film for experimental companies, the following question was completed by experimental and control subjects: "Do you think you will make a good adjustment in basic training? Answer Yes or No." Four weeks later the questions in Table 1 were asked of experimental and control subjects.

In the last week of basic training the questionnaire in Table 2 was administered to the trainees in the experimental companies.

TABLE 1

Questionnaire presented to subjects in fifth week of training

Have you been able to make a good adjustment during the past four weeks? (Answer Yes or No)

If so, which of the following have been the most helpful? Rank in order of helpfulness (1—most helpful, etc.)

- () Letters from home
- () Friends in your company
- () Mental hygiene lecture *
- () Orientation lecture by regimental commander
- () 1st Sgt. and company commander

* For control companies the regularly scheduled "chaplain's lecture" was substituted.

TABLE 2

Questionnaire presented to subjects in final week of training

As you recall you saw a film entitled "Adjustment to Military Life" early in basic training. This film was presented by the Mental Hygiene Consultation Service. Read each statement and decide whether you feel it is true or false. Circle your answer (T or F). Answer all statements.

1. The film given by the Mental Hygiene Clinic has helped me adjust to Army life. T F
 2. The mental hygiene film should be given to basic trainees. T F
 3. I feel there are much better methods than the mental hygiene film which may be used to help one adjust to military life. T F
 4. This film did not help any of my friends adjust to military life. T F
 5. This film should be replaced by a lecture on the same topic. T F
 6. Neither a lecture nor a film by the mental hygiene service should be given to basic trainees. T F
 7. The mental hygiene film helped me learn what feelings I would have in basic training. T F
 8. This film helped me avoid AWOL in basic training. T F
 9. This film did not reduce the number of times I visited the dispensary. T F
- How can we improve the film? (Answer)

Note: The number of italicized answers circled by the subject constituted his film acceptance score.

Basic infantry proficiency test scores¹ (PP), marksmanship scores (TF), physical training test scores (PP), and number of visits to the dispensary were utilized as criteria for evaluation of the effects of the video presentation.

RESULTS

Two separate correlation matrices are presented in Tables 3 and 4, one for the experimental group, and one for the control group. Correlations are presented between

intelligence as measured by the General Technical score of the Army Classification Battery, the criterion variables, the ranking of the chaplain's lecture or mental hygiene presentation, and in the case of the experimental group, the film attitude scale. The appropriate t-tests are presented in Table 5.

There are significant differences between the experimental and control groups in that the subjects who viewed the video presentation were superior on the battery of proficiency tests and on the physical training test. There are no differences in number of dispensary visits or marksmanship. The questions as to whether the trainee feels he will adjust to the service presented immediately following and four weeks after the film, and at similar points in the training cycle of the control subjects, approach significance in the expected direction. The chaplain's lecture was perceived as more helpful than the video presentation, although both were markedly low when compared with the other influences listed in Tables 1 and 2.

DISCUSSION

It is interesting to note that although, overall, the number of sick call visits was not affected by the presentation, there is a significant negative relationship between intelligence and number of sick call visits in the group that saw the presentation, but no such relationship in the control group. Another criterion directly related to viewing the video presentation was the diversified battery of proficiency tests. This is highly related to intelligence.

It appears then that there is some evidence for a differential effect of the presentation based on levels of intelligence.

¹ This is a diversified battery of tests to determine the trainees' knowledge of subjects taught during the eight weeks basic training course. Marksmanship and physical training are not included.

TABLE 3

Intercorrelation matrix for experimental group

	2	3	4	5	6	7	8	9
	Ad #1	Ad #2	Sick call	PT	TF	PP	MH ^a lect	FA scale
1. GT	-.01	.06	-.15	.05	.01	.43	-.08	-.27
2. Ad #1	..	.35	-.08	.07	.01	-.04	-.08	.08
3. Ad #2	-.09	.04	-.06	-.04	-.02	.09
4. Sick call	-.12	.01	-.13	.05	.01
5. PT12	.14	-.10	.00
6. TF08	-.08	.08
7. PP	-.03	-.11
8. MH lect15

Note: With minimum N=245, r of .138 significant at .05 level and r of .181 significant at .01 level.

^a This variable was rotated for ease of interpretation so that 1=least helpful.

TABLE 4

Intercorrelation matrix for control group

	2	3	4	5	6	7	8
	Ad #1	Ad #2	Sick call	PT	TF	PP	Chap ^a lect
1. GT	-.05	-.01	.03	-.01	-.03	.42	-.13
2. Ad #1	..	.33	.04	.05	.05	.03	-.09
3. Ad #2	-.02	-.03	.03	.08	-.01
4. Sick call	-.08	.01	-.08	.08
5. PT07	.13	.00
6. TF16	-.01
7. PP	-.04

Note: With minimum N=245, r of .138 significant at .05 level and r of .181 significant at .01 level.

^a This variable was rotated for ease of interpretation so that 1=least helpful.

TABLE 5

Means and standard deviations of experimental and control groups with t-tests

Variables	Experimental group			Control group			t
	N	Mean	S.D.	N	Mean	S.D.	
GT score	560	113.25	18.26	525	113.66	19.40	.35
Adjustment question #1	561	.93	.25	523	.90	.30	1.66
Adjustment question #2	473	.96	.20	445	.93	.25	1.80
Number of sick call visits	478	.56	1.15	522	.56	1.00	.00
Physical training test score	455	341.83	55.77	385	318.90	59.35	5.74
Trainfire (rifle) score	524	50.57	10.05	513	50.19	9.13	.64
Proficiency test score	480	88.20	5.57	401	83.51	5.97	11.98
Mental hygiene video (Exp gp) versus chaplain's lecture (cont gp)	480	1.01	1.05	451	1.19	.98	2.81

Note: With $df=500$, t of 1.965 significant at .05 level and t of 2.586 significant at .01 level.

The brighter subjects tended to benefit more from the video presentation and improve their performance. This is clearly demonstrable in the case of the dispensary visits. It is interesting in this regard to note that there is a significant negative relationship between intelligence and attitude toward the presentation. Thus, although the more intelligent subjects tended to dislike the presentation, they modified their behavior appropriately, at least in regard to the number of dispensary visits.

One objection that may be raised to the design of this study is that although the number of subjects studied is relatively large, the number of companies in each group is small and the differences found might well be a result of differences between companies. The performances of these companies on the previous training cycle was obtained. It was found that the experimental companies performed better than the control companies on the proficiency test, but the control companies performed better on the physical training test.

Thus, the reversal of the physical training test scores appears to be related to the video presentation, but some doubt is cast on the effect of the video presentation on proficiency test scores. Since there are great practical difficulties in getting a relatively large sample of large groups it might be advisable to place one part of a group in the experimental condition and another in the control condition in a replication of this study, or in any study in which the effects of a manipulation on performance of individuals in large groups is to be studied.

Although the intercorrelation among criterion measures are very low, these criteria appear to hold more promise than the dysfunction rates used by Gottheil and Lubetsky, Kisel and Blume. Gottheil was not able to demonstrate the effects of a film

presentation on dysfunction rates and Lubetsky, *et al.*, were not able to demonstrate effects of a consultation program on these rates.

SUMMARY

Subjects who viewed a mental hygiene video presentation performed better on basic infantry proficiency tests and physical training tests when compared with subjects not viewing the presentation. There was no difference in marksmanship scores. There were no over-all differences in number of sick call visits but subjects who saw the film and had higher intelligence test scores tended to make fewer dispensary visits than subjects who saw the film and had lower intelligence test scores. Implications for criterion development and experimental design of outcome studies are discussed.

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Psychiatric role of physical medicine and rehabilitation in the third revolution

We are in the midst of a revolution, a revolution related to the care, treatment and entire philosophy of the mentally ill. While it is true that there has been a continuing change from year to year and from decade to decade, the really discernible, discreet difference in dealing with the mentally disturbed seems to have occurred in three separate steps or stages.

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¹ Rapaport, Robert N., *Community as Doctor: A New Perspective in a Therapeutic Community* (Springfield, Ill.: C. C. Thomas, 1960).

² Zilboorg, Gregory and George A. Henry, *A History of Medical Psychology* (New York: W. W. Norton & Co., Inc., 1941).

Let us take a cursory look at these first two revolutions for a perspective of the current upheaval in psychiatric concept and practice, with particular reference to the physical medicine and rehabilitation therapist, who is closely related with patients in the live-work-a-day situation.

Rapaport, in his recent book *Community as Doctor, a New Perspective in a Therapeutic Community*,¹ reviews those historic origins. He cites Zilboorg² who states that the first revolution in near-modern times occurred in the sixteenth century, as evidenced in the works of Agrippa and Weyer. They fought against the superstition and brutality which characterized the Middle Ages and achieved real progress in bringing about more humane attitudes toward the insane. The Renaissance and Reformation, of which they were a part, lasted for over two centuries and culminated in the work of

Pinel in France, Tuke in England and Dorothea Dix in the United States. *Moral treatment*, which emphasized the adoption of warm and kindly attitudes toward the patients, along with constructive work, was the point of greatest achievement and the culmination of this era which started 300 years before.

Moral treatment was well-defined in its day. Brigham³ writing in 1847, defined it as "removal of the insane from home and former associates . . . respectful and kind treatment under all circumstances . . . a healthy amount of manual labor . . . attendance at religious worship and the establishment of regular habits and self-control along with the diversion of the mind from morbid trains of thought." Even though the moral treatment concept was the highpoint of the first revolution, there is some question as to whether or not it was ever the dominant philosophy and practice in this country.

During this period, neuropsychiatric hospitals (or asylums as they were called) were most often places where the so-called "acute" either recovered spontaneously or became chronics and were stored away for a lifetime. There was no rehabilitation.

The second revolution was slow in coming, and although its main perpetuator wrote his first meaningful paper—meaningful in the sense of dealing with the mentally ill—in 1893, it was not until almost the middle of the present century that its effect made itself felt in the mental hospitals, and contributed particularly to the evolution of the concept of rehabilitation. This apocalypse did not originate in the mental hospitals but from the private treatment of neurotics. Its founding father was Sigmund Freud. At first this psychoanalytic theory and method had little to do with either hospital operation or rehabilitation. It was a specific treat-

ment method only. Soon, however, it made itself felt in the hospitals, both as a theory and as a practice.

The main contribution and change brought about by this second revolution was the linking of treatment to the understanding of the patient in his whole life situation, which involved the social as well as the biophysical elements. The patient was seen as a biophysical entity and attempts were made to understand his whole life situation.

The psychically disordered individual was thought of as a whole personality which had been malformed because of faulty early emotional development in the family. Treatment and rehabilitation became less distinct one from the other during the latter part of the second revolution. Before this, rehabilitation was most often thought of as something which took place after the symptom removal or treatment; for example, only after the ECT or insulin therapy was rehabilitation begun. It is during the current third revolution that the final merging is taking place, and for many today rehabilitation and treatment are synonymous.

What is this third revolution now taking place? Who started it? What changes is it bringing about? How do these changes affect the physical medicine and rehabilitation and other adjunctive therapists? The last question is perhaps the most difficult to answer, so will be left for last.

The idea of a mental hospital operating as a community—a therapeutic community—became evident in the middle of this century. It is an effort on the part of the mental institution to provide a type of environment which effectively helps whatever other treatment the hospital may pro-

³ Brigham, Y., "Moral Treatment of Insanity," *American Journal of Insanity*, 6(1847).

vide. It has its basic foundation in the area of group dynamics and, like moral treatment, it stresses providing a favorable, community-like environment for the patients within the hospital. This was its rather vague beginning and it gained most of its impetus from Maxwell Jones,⁴ a psychiatrist in England, who wrote the foundational book entitled *The Therapeutic Community*.

Jones set up a specific treatment ward in which the main treatments were group meetings, discussions, and specific work responsibilities. These group meetings were unlike traditional group psychotherapy (for one thing they evolved the whole ward rather than small groups of patients), and the work assignments were for productive labor, not merely activities to occupy time. Rapaport⁵ has given five general concepts which led to the development of this therapeutic community concept.

1. A reaction against the undesirable aspects of the custodial system.
2. The application of psychoanalytic ideas to new situations—like hospitals and homes for delinquents.
3. The influence of social service ideas.
4. A response to the exigencies of war.
5. A renewed awareness of certain colonies like Gheel, Belgium, where mental patients lived openly in communities.

Rapaport also lists five common elements of the therapeutic community which seem to characterize this third revolution. These are:

- a. The total social organization (the hospital) in which the patient is involved is seen as affecting the therapeutic outcome, and not only his relationship with the doctor (or psychotherapist).
- b. The social organization is not re-

garded as a routinized background to treatment but as a vital force useful for creating a milieu that will maximize therapeutic effects.

c. The core element in such an institutional context is the provision of opportunities for patients to take an active part in the affairs of the institution. This is sometimes called democratization.

d. All relationships within the hospital—those of patients among themselves as well as patients with staff—are regarded as potentially therapeutic.

e. A high value is placed on communication as such. One part of this is administrative—that it is good for people in one part of the organization to know what people in the other parts are doing, thinking and feeling. Furthermore, the act of communicating is thought to have an important moral and therapeutic effect for staff as well as patients.

Hospitals vary in the degree to which they implement these viewpoints and to which of these five elements they give the most importance. To our knowledge there is only one large hospital in the United States which is trying to implement the therapeutic community exactly as it was done in England, but most American neuropsychiatric hospitals and VA hospitals in particular have been affected and changed by this new philosophy of treatment. Many of our newer approaches such as foster home placement, halfway houses, restoration centers, certain of our industrial therapy programs such as CHIRP and PEEP, our patient government and patient councils, and, most pertinent, the unit system certainly are movements toward if not an embodiment of the therapeutic community concept.

Parenthetically, and to give emphasis to the generality of this movement, the mental health program President John F. Kennedy presented to Congress in February of 1963 stresses community mental health centers

⁴ Jones, Maxwell, *The Therapeutic Community* (New York: Basic Books, Inc., 1953).

⁵ Rapaport, *Ibid*.

rather than hospitals or "outmoded types of institutional care which now prevails." Such things as day and night care, foster home care, etc., are specifically mentioned as part of these community centers. In addition, at least three novels appeared in 1963—one with the intriguing title *One Flew Over the Cuckoo's Nest*—which centered on the therapeutic community treatment idea.

Back to our original questions concerning the third revolution. What is it? It is a theory and practice which sees the total hospital experience as a relearning situation in which the relationships among the people who live there—both patients and staff—is considered the most important treatment modality. It tends to break down, blend and merge many of the old classifications and categories as to what is or who does treatment and therapy. Its start is generally attributed to Maxwell Jones in England, although many in this country—Stanton and Schwartz,⁶ Caudill,⁷ the Cummings,⁸ and Rapaport⁹ have advocated, evaluated and perpetuated its development.

Our third question was: what changes is this revolution bringing about? Like any revolution there has been turmoil and conflict, claims and counterclaims, excesses and abuses, those who, while accepting its basic tenets, have changed its application. As previously mentioned, one large neuropsychiatric hospital hired Maxwell Jones to set up his type of "pure" therapeutic community. Many state hospitals and private institutions have initiated wards and special units where the therapeutic community has been the main approach to treatment.

In the Veterans Administration, it is our personal observation and opinion that we have moved into the therapeutic community approach to treatment in an oblique manner, and on three separate fronts. First,

we have tried to make the hospital more community-like by opening its doors to those outside—in other words, by bringing the prevailing community into our hospitals. We have done this mainly through volunteer workers who no longer are thought of as those people who come into the hospital with a basket, like little Red Riding Hood, to dispense cigarettes, candy and goodies. Rather they are conceived of as a social treatment, a method of providing a continued social intercourse which maintains community ties and identification. This bringing into the hospital of employees to conduct real or simulated job interviews is another facet of this, and even the bringing of contract work into the hospital exemplifies this trend of opening doors to the community.

The second approach has been a democratization within the hospital. Now a neuropsychiatric hospital without some type of patient government or without a paid-employee program is considered backward. The unit system which has been extended to 16 of the 35 VA hospitals shows this strong democratization approach. This is attested to by the following statements of Dr. John Blasko,¹⁰ chief of the Psychiatry, Neurology and Psychology Service of the Veterans Administration. "In the unit system doctors and staff get to know each patient intimately and will eventually become friendly with

⁶ Stanton, Alfred and Morris Schwartz, *The Mental Hospital* (New York: Basic Books, Inc., 1954).

⁷ Caudill, William, *The Psychiatric Hospital as a Small Society* (Cambridge, Mass.: Harvard University Press, 1958).

⁸ Cumming, John and Elaine Cumming, *Ego and Milieu* (New York: Atherton Press, 1962).

⁹ Rapaport, *ibid.*

¹⁰ Blasko, John J., in *VA Vanguard*, 9(February, 1963), No. 18.

members of the patients' families" and "where disturbed patients tend to adapt the more normative behavior of the group and react quickly to the displeasure of the group."

As mentioned before, the establishment of the unit system is perhaps the most potent indicator of the change that is taking place within the neuropsychiatric hospital and would appear to be a direct reflection of the therapeutic community influence or, in our terms, the third revolution.

The third front on which the Veterans Administration is moving is in the direction of taking the hospital into the community. The first step provided a liberalization of town passes following an "open door" policy. Concomitant with this was the setting up of foster home programs, then the halfway houses and sheltered workshops, and, finally, the newest approach is the utilization of community resources such as movies, swimming pools, municipal park parties, etc., rather than having these provided within the hospitals. This third approach emphasizes the importance of keeping the patient and his activities in the community wherever and whenever possible.

Let us make a brief resumé at this time to bring us to the last major point of this paper. We have suggested that we are in the midst of a major change—a revolution—in the care and treatment of the mentally disturbed. This was preceded by two other changes, the first culminating in the so-called moral treatment and the second reflecting the influence of the psychoanalytic movement.

This current upheaval started with the therapeutic community concept and practice and has already made itself felt in major changes which have taken place in our hospitals. In the broadest sense, the therapeutic community philosophy implies

that treatment and rehabilitation for the psychiatric patient is best brought about by a continuation of communal interpersonal experiences.

The Veterans Administration has implemented this philosophy by bringing the community into the hospital, making the hospital more community-like and by moving the hospitalized patient back into the community whenever and wherever possible. Almost all of our newer programs have been oriented toward serving these ends.

Now to address ourselves to the last of the questions concerning this contemporary approach. How does the physical medicine and rehabilitation therapist fit into this brave new world? Before trying to answer this question directly we must look at one more effect of the therapeutic community influence. That is, the way in which it conceives of rehabilitation. It was during the period of psychoanalytic influence that rehabilitation came to the fore with Rusk's three different stages of medical activity—diagnosis, treatment and rehabilitation—defining concisely the parameter of rehabilitation.

In the newer, avant-grade approach we find Maxwell Jones and others maintaining that all psychiatric treatment is rehabilitation and there is no distinguishing between the aims, personnel or processes of rehabilitation and those of treatment. The whole foundation of social psychiatry would also seem to reinforce this concept.

Here we are at the choice point. If rehabilitation ceases to exist as a separate entity in the treatment of the neuropsychiatric patient, what do we do? What is the role of the rehabilitation therapist in this New Frontier?

While it would be presumptuous to give a categorical answer, even if we were capable of doing so, some things seem ap-

parent. First there will be increasing dissatisfaction with our assigned roles if they do not reflect a part in this new approach. Secondly, in terms of background experience and training, the rehabilitation therapist, and especially the activity therapist, is uniquely equipped to contribute more than ever to the mission of our neuropsychiatric hospitals.

At this point let us be specific. One can conceptualize two separate and somewhat discrete roles which the rehabilitation therapist will be filling and both of these will involve a move from his "ivory clinic." One of these roles will be that of unit member within the hospital, and the other will involve his functioning much more in the community.

As a unit member, the therapist will have to get used to the idea that what he says, does and feels toward the patient is equally important and/or as much a part of treatment as the patient's experience with the nurse, psychologist or physician. In addition, he will come to know the patients and staff in a much more intimate way than has been possible in the past. It will be a living-and-working-with rather than applying-treatment-to kind of existence. In this new context the way in which the therapist relates to his co-worker becomes as important as the way he relates to the patients, for it is these total interpersonal relationships that form the unit society in which we are asking the patients to participate.

The rehabilitation worker's behavior becomes as much a part of the environment to be discussed and analyzed as does the behavior of the patient. One the rehabilitation therapist realizes and accepts

that this learning-to-live-together in an adaptive manner is a prime part of treatment, he will indeed become a part of the therapeutic community. The cabinet which the patient makes, the rug he weaves or the ball he catches becomes important in this context only as skills to be learned so that the patient can more easily learn to live and compete with others and, most important, so he can learn how people do things together.

The second area of new activity which we envision is the following of the patient into the community or into the way stations (such as halfway houses or sheltered workshops) we now find affiliated with many of our neuropsychiatric hospitals. By definition the physical medicine and rehabilitation therapists should be key personnel in these operations as well as in the newer industrial therapy programs such as CHIRP and PEEP. It seems logical that this working outside the physical confines of the hospital could be extended to such things as having industrial work or work care visits in much the same manner that we now have home or family care visits. Surely each of you can see even further application of this follow-the-patient-into-the-community concept.

It is evident that some of these things are not presently possible in many of our hospitals. However, we firmly believe that we are in the midst of a third revolution, a revolution which is moving us swiftly into a new concept of care and treatment of the mentally disturbed. Already we are challenged to find new appropriate roles which will adapt our professions to meet these changes.

Implications of process-reactive schizophrenia for rehabilitation

The increasing volume of referrals of post-schizophrenics to vocational rehabilitation services brings into focus a long-standing stumbling block which has precluded development of more efficient comprehensive vocational rehabilitation programs for schizophrenics.

This problem is the lack of reasonably accurate prediction of potential for successful rehabilitation in individual cases. Recent research has opened the way to just such a predictive technique. To acquaint the vocational rehabilitation counselor with this newer research on schizophrenia, and to suggest how it may be used to direct presently diffused vocational rehabilitation efforts to an area where they may be concentrated with greater efficiency and success, are the major aims of this paper. The last section will give a brief description

of current therapeutic-rehabilitation programs in this country.

INCREASE IN REFERRALS

Data on the total number of referrals of schizophrenics to vocational rehabilitation services are not available, because of their usual inclusion in more general categories; however, other data, combined, serve to indicate considerable increase in such referrals.

According to National Institute of Mental Health figures reported by Kramer, *et al.*, the 32 per cent increase in incidence of schizophrenia recorded from 1940 to 1950 has continued to increase, as has the rate of hospital discharge: "The year-end [resident-patient] population [in the U. S.] at the end of 1958 was 52,000 less than would have been expected on the basis of the trend in the period 1945-1955. The reversal in the trend . . . was accomplished not by a decrease in admissions, which

have adhered reasonably well to their increasing trend line, but by an increase in the number of net releases . . . which have increased consistently above their 1945-1955 trends by considerable amounts" (22).

The well-known increase in the general population has swelled the actual number of cases encompassed by these rates. Since, according to Bertram Black, "over 65 per cent of all post-psychotics referred to OVR programs each year are in the schizophrenic category" (3), it follows that vocational rehabilitation case loads reflect the upward trends. It is also reasonable to assume that they will continue to rise in the future, if only on the basis of general population increase.

THE VOCATIONAL COUNSELOR'S DILEMMA

Rehabilitation people seem to share a pessimistic attitude toward schizophrenics, as expressed by Bertram Black: "In speaking of the post-psychotic rehabilitee one must not, at this stage of treatment progress, be overoptimistic about vocational potential. In general, this is a group of poor risk persons for job placement. Their performance on a job, though often industrious and consistent, will likely be in the lower quartile range. It is very hard for employment counselors and vocational placement people to wax enthusiastic about them, or for employers who 'try them out' to put up with the slowness of rise in productivity and the constant threat of breakdown. Employment specialists speak of these kinds of persons as 'employable' but not readily placeable" (3).

The individual vocational rehabilitation counselor's agreement is reflected in an unpublished memorandum from the California Vocational Rehabilitation Service dated February 15, 1962, which states that unemployed closure of psychotics (72.6 per

cent schizophrenics) is credited significantly more often to "too emotionally unstable" than any other single cause.

Further, although almost as many funds are expended on closed unemployed cases as on closed employed, a significantly larger proportion are closed unemployed within 12 months after acceptance than are other nonpsychotic mental hygiene clients. "Apparently counselors are inclined to hang on to . . . [the other mental hygiene clients] indefinitely before [unsuccessful closure] . . . but they are able to make up their minds faster with psychotic cases."

This unfavorable attitude appears incongruous with the impressive percentages of success reported by various integrated rehabilitation programs with long-term chronics, notably the Altro Workshop Program in New York and Rehabilitation House in Vermont (3, 7). The California memorandum observes, "The rather surprising point is coming out of these figures that psychotics represent as good or better bets for rehabilitation than . . . [the other nonpsychotic mental hygiene clients]."

These incongruities point up the crux of the rehabilitation counselor's problem with post-schizophrenics: he adopts a generally unfavorable attitude out of frustration, for *while he knows that some of his cases will respond successfully to a rehabilitation program, he also knows that others will not, and he has no way of telling in advance which is which.*

For example, the aforementioned memorandum comments that if foresight at acceptance could "catch up with hindsight at time of unsuccessful closure, better programs . . . [might] be devised to reduce the significantly greater proportion of mental hygiene clients than of the general load now closed unsuccessful."

The memorandum goes on to advise that "The counselor needs to become a student

of the mental disorders so that his interview data become more meaningful," and to suggest that the counselor might devise his *own* predictive techniques through administration of a standard battery of tests to *all* applicants, of whatever disability, and comparing the results. This is deemed "less difficult than adjusting two variables, that of the client to that of the counselor's subjective evaluations, or his understanding of a specialist's interpretations."

While the author hastens to advise assimilation of "specialists' interpretations" in judging rehabilitation potential, the implication is clear that they have been inadequate for the situation. This implication is expressed openly by Zubin, *et al.*: "Most clinical prognoses are purely impressionistic and their over-all accuracy is generally so low that it is not surprising to find many clinicians utilizing the prognostic category of 'guarded' in self-defense" (30).

With employment of a new concept of schizophrenia as a process-reactive continuum, a way has been opened recently for more accurate prediction, utilizing the Rorschach Ink-Blot Test, which will be described in a later section. This predictive technique appears to offer a more reliable alternative than either clinical prognosis or a counselor's self-devised method.

Understanding the significance of this new technique and the previous uncertainty of prognosis requires some knowledge of the historical development of psychiatric attitudes toward schizophrenia.

HISTORICAL DEVELOPMENT

Kraepelin's designation, late in the last century, of the dementia praecox syndrome (21), categorized on the basis of symptomatology and viewed as only another form of incurable psychosis, set the stage for a particular kind of viewpoint

which persisted until recent years, in spite of Bleuler's valuable work in the early part of this century, which showed that some sufferers were curable (5).

For this reason, Bleuler suggested renaming the illness "schizophrenia" indicating a split of the mentality without the earlier connotation of hopelessness. Unfortunately, while the name was adopted, the older approach was retained: that of nosology based on symptomatology. This approach alone has accounted for a great deal of confusion, since the overlap of types and variation from one type to another over a period of time are common, along with unpredictable regressions or remissions.

This has resulted in all-too-frequent re-diagnoses or contradictory diagnoses by different clinicians, and in new designations of atypical, so-called schizophreniform categories. Throughout the nearly 50 years since Bleuler, a massive amount of research has been done on schizophrenia; yet, generally, until recently it remained little better understood because of numerous contradictions in findings.

RECENT RESEARCH

The implications of a particular series of studies over the past 10 years (17, 18, 19, 29) are of interest here, since they cut through the confusions and contradictions. They utilize a different rationale of schizophrenia, and have indicated some fruitful results. Over the years gross observation by certain investigators has shown that some schizophrenics recover rapidly, some even without therapy, and that others regress into varying stages of deterioration lasting for many years or a lifetime and they thus assumed that schizophrenics are a heterogeneous group, rather than homogeneous as assumed by former investigators. So Kantor and Winder proposed a

dichotomy of schizophrenia, calling the malignant group "process" and the benign group "reactive."

The differentiation was empirically demonstrated by Rorschach Test and described in the *Journal of Consulting Psychology* in 1953 (17), receiving favorable response from other workers such as Rabin and King, who declared that some of the contradictions found in an extensive review on such tested performances as thinking, perception, learning, intelligence and even physiology, would disappear when schizophrenia was approached from the process-reactive point of view (26). Becker helped to confirm this prediction in a 1959 paper (2).

Part of the process-reactive approach was derived from setting aside symptomological criteria as misleading, and utilizing the general clinical observation that schizophrenia is always associated with some degree of defective self-perception, or a mutilated self-concept. Contemporary personality theory holds that the self-image is created out of childhood identifications in response to expressions of approval and disfavor by significant persons, and as Harry Stack Sullivan noted (27), the dynamics of the self are energized throughout life by anxiety generated by these early-constructed patterns of response.

With special attention to Sullivan's dictum: "It comes about that the self . . . is the only thing which has alertness, which notices . . . what goes on in its own field," Kantor and Winder hypothesized that a defective self-perception, whether regressed or immature, would be accompanied by primitivized perceptual or cognitive organization. This could be measured by Rorschach comparisons with established age norms and correlated with life-history and premorbid adjustment. The resulting score was an *Index of Social Maturity* achieved

before onset. The hypothesis was confirmed and the positive results were published in 1958 (29) and precisely matched in a more elaborate study in 1961 in the *Journal of Nervous and Mental Disease* (19).

Using the theory that normal development proceeds in stages of maturation and self-integration, and that schizophrenia is a result of deprivation or insult during some early stage of development, Kantor and Winder (18, 19) not only constructed and verified a quantitative measure on the basis of the Rorschach and correlated it with developmental history, but also expanded the process-reactive dichotomy into a continuum.

According to these workers, five major groups are distinguishable in schizophrenia, corresponding to the five stages of normal development described by Sullivan, in each of which integration of a central problem must be at least partially achieved before further successful psychological growth can occur. Starting at the process end, the most lethal form of schizophrenia results from the person's inability, in the first infantile stage of his life, to cope with maternal rejection; infantile self-definitions predominate in such a person with such consequent conduct patterns as uncontrolled toilet habits, absence of language, and the profoundest deficiencies of intellect.

The next most regressed form of schizophrenia occurs where there is inability to deal with the second stage of life when the most rudimentary symbolization processes begin; such schizophrenia shows some elements of a self-picture accompanied by gross disorganization and profound hallucinations.

In the third stage of life, the central problem focuses on the ability to grasp connections between events; failure here prevents the formation of a detached view

of the self and therefore results in schizophrenic manifestations of magic and grandiose thinking.

Mastery of manipulable symbols—language, for example—is the central concern of the fourth stage of life, and insufficiencies here show up in such schizophrenic ways as personal languages with private, unshared meanings; paranoid delusions commonly result from this type of solitary and untested thinking.

The fifth-stage problem centers on the development of a working consensus with society; the person who breaks down at this stage usually has achieved a firm self-picture, mastery of language structures and easy interpersonal relationships. This fifth stage represents the reactive pole of the continuum; schizophrenia occurring in such an individual, usually under circumstances of recognizably severe environmental stress or shock whose repetition is unlikely, has a favorable prognosis.

In brief, then, a fruitful approach to schizophrenia is through the maturity of the Rorschach and correlated to life history, the self-system as measured by the Rorschach and correlated to life history. Prediction becomes possible concerning the severity and the recovery-potential of any schizophrenic case: earlier and more extreme fragmentations of the self-image are associated with process schizophrenia, while the later and less severe self-disintegrations are associated with the reactive type.

DESCRIPTION OF REACTIVE SCHIZOPHRENIA

Aside from rapidity and violence of onset, with frequently florid symptoms such as excited and bizarre ideation and massive confusion, there is little to distinguish the reactive from the process type at first glance; the differences are more a matter

of degree, with the process type more withdrawn and quieter. Violence of onset, the most readily recognizable characteristic, and source of the general designation "acute," appears more spectacular by its contrast with premorbid adjustment, which is relatively normal in the reactive. In the process type, onset is more gradual, the break is less apparent, and frequently goes unnoticed for amazingly long periods, sometimes years, by families accustomed to his eccentric behavior and peripheral existence. Anxiety is more apparent in the reactive, along with great puzzlement and stronger sensitivity to environment, contrasted with the process type, whose anxiety is masked by withdrawal into autistic pre-occupations.

Later, the reactive may "snap back"—spontaneous remission rate has traditionally been around 40 per cent—(4), or recover more slowly. The recovery potential of the reactive or "acute" is demonstrated by a study of the yearly status for five years of the first 100 patients admitted to Boston Psychopathic Hospital after June 30, 1946 (14). Note that this was before chemotherapy. "Of those living and in the state, 78 per cent were in the community at the end of the first year and in successive years, 85, 86, 88, and 86 per cent. . . . After five years, 51 per cent had never been readmitted." These are clinical observations with a long history; they are still valid as far as they go. However, they are too crude for reliable prediction. The Rorschach Index of Social Maturity offers greater advantage.

ABILITIES AND NEEDS OF ACUTE REACTIVE SCHIZOPHRENIC

Several factors serve to indicate that a considerable proportion of acute reactive schizophrenics do not receive vocational rehabilitation services. A survey of state

mental hospitals in 1960 showed only a median number of 15 patients at 50 reporting hospitals, with only 1 to 2 per cent vocationally placed (10). Huseth states there are only 14 transitional houses presently in existence, not all of which take acutes; further, their size is limited, usually to fewer than 20 at a time (15).

Recall the high release rates mentioned earlier; Wechsler cites the total mental hospital discharge in 1956 as over 200,000 (28). In California, during the year ending June 30, 1961, over 5,500 mental patients were discharged from state mental institutions alone. The State Vocational Rehabilitation Service memorandum already cited reports processing only 74 schizophrenic cases, most of whom had been accepted and closed in that same period. While not all those discharged were schizophrenic and the VA is known to account for a considerable proportion of male schizophrenics, the gap is still far too large to assume that many schizophrenics are funneled into the California State Vocational Rehabilitation Service, and it is reasonable to assume that the condition is approximated nationwide.

This is supported by Olshansky's statement: "The majority of expatients find their jobs informally, through their own efforts or those of friends and relatives. . . . The fact that the majority of expatients enter the labor market in a way which accords with labor market traditions and employer expectations (that is, without professional assistance) also serves to explain, in part, their ability to find employer acceptance" (25).

Ewalt also observes, in regard to acute patients: "[They] recover promptly [and] often retain their social skills and know-how for living in the community. Many of them return to their original jobs and in many instances present less difficult prob-

lems than . . . the chronic patient." He goes on to comment that acute patients may profit from abrupt discharge without transitional programs, as it "may actually have strong points in tending to promote self-reliance and independence in the individual" (12).

This rather comfortable attitude is unreal, for while the acute shows a greater ability to find profitable employment than the chronic, Olshansky finds that "expatients *as a group* need and/or want active professional intervention in negotiating their return to the labor market" (*italics his*).

However, *their even greater need is in the social area*, as shown by Greenblatt: "When we ask what is the level of adjustment of discharged [acute] patients . . . several threads of evidence can help us. A study by Linder and Landy (23) tells us that 75 per cent of male expatients followed up for two years were working in the community—the large majority, full-time. Earnings were generally up to pre-illness level. However, although the occupational adjustment of these acute, discharged mentally ill is encouraging, it is usually found that the community and social adjustment lags far behind."

These seem to represent the more successful (14), for Olshansky describes another group which shows a record of employment, but with frequent change of jobs; of them, he says ". . . , socially this group were generally living lives of isolation and loneliness, lives of quiet desperation" (25). The suggestion is that further measures are needed to help these people; mere job-finding is not enough. More attention to social integration by vocational rehabilitation services is indicated here, if no more than the organization of expatient social clubs such as the now-venerable Fountain House in New York City.

It is our belief that the major efforts of the nonspecializing casework vocational rehabilitation counselor could be most readily rewarded by concentration on the acute or reactive schizophrenic, with the aid of an accurate predictive technique such as the Social Maturity Index, fully described in a recent article (9). The rehabilitation of the chronic schizophrenic is not hopeless, but seems most successful when attacked by concentrated teamwork, to which the vocational rehabilitation counselor can contribute and has, as shown by the studies of Wechsler and Huseh of transitional facilities, and those of Durling and Barton of in-hospital rehabilitation programs (28, 15, 10, 1). This, however, is a function outside the operation of the majority of vocational rehabilitation counselors, both for lack of opportunity and adequate specialized knowledge of mental illness.

TRANSITIONAL PROGRAMS FOR MENTAL PATIENT

Huseh (15) and Wechsler (28) have surveyed a variety of programs designed for easier entrance into the community for the discharged mental patient who has been away from society long enough to have lost social skills and family and employment status. According to Huseh, "Since the community usually expects and demands a higher level of performance than the hospital, sheltered workshops and, more recently, member-employee programs have been instituted within the hospital to prepare the patient to assume a productive role in the outside world." The problems of the patient, however, "do not end with his vocational adjustment. One study found that work was almost the last area of the patient's life which showed the effects of emotional disturbances" (15). Therefore, paramount emphasis is given to social needs, in the form of day and night

hospitals, foster-family care, halfway houses and ex-patient social clubs.

Wechsler cites work organizations in the form of rurally situated work camps, whose facilities are also used by inmates, without hospitalization histories, in stress situations. These programs are in addition to after-care clinics provided by many hospitals, and the types of programs named are generally closely associated with hospitals.

Both the transitional facilities and in-hospital therapeutic-rehabilitation programs appear to have been stimulated by older British programs which have proved successful, notably the group homes sponsored by the Mental After-Care Association in which most of its patients are housed (15), and Maxwell Jones' therapeutic community (16). These programs are basically oriented toward the concept of man as essentially social and continually responsive to the total social environment; their aim is to construct a therapeutic social environment. American programs are not counterparts, existing in a different culture and dealing with different kinds of problems, one major difference being more active participation of the British Government.

Increasing the efficiency of the American programs has been the author's purpose.

SUMMARY

This paper has attempted to set forth the following major points:

1. There is an increasing problem faced by rehabilitation services in dealing with schizophrenia, which is aggravated by lack of ability to predict potential for successful rehabilitation in individual cases.

2. A new technique for prediction, a sensitive Social Maturity Index, capable not only of sorting favorable from less favorable, but of predicting degree of potential, is available.

3. With the use of the Social Maturity

Index, vocational rehabilitation services can concentrate purposefully on the various needs of the reactive schizophrenic, whereby the optimal efforts of medical therapy could be freed to concentrate on the more malignant types of schizophrenia.

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Basic issues and problems in attendant training

The general shift of emphasis in mental hospitals from custodial services to concern for the therapeutic function has resulted in changed perceptions about the role of the attendant employee. As Chen (3) has pointed out, we no longer can afford to use the aide as a mere custodian. He must become an active member of the multidisciplinary therapeutic team. The awareness of the changing role of attendants has resulted in increased attention toward developing the aide's potentials through emphasis on attendant training (11, 12).

The general area of training is quite complex, perhaps more so than one realizes. One factor contributing to the complexity is the vast amount of literature available which must be screened to enable one to see the forest as well as the trees. Much of the literature is centered around descriptions of programs, and empirical evidence appears limited.

Another factor contributing to complexity is the realization that training is only one of the many facets of an organization, and that it is markedly influenced by the many other programs operating at the same time. It is, in reality, a part of a system composed of selection, placement, equipment design, organization structure and many other elements or units, all of which exist in an interdependent fashion.

Such a "system" concept has been advocated by Dudek (6) in his review of personnel selection, where he mentions several articles that were concerned with the relation between personnel selection and such things as placement, assignment, training, manpower utilization, etc. Although the present paper does not actually deal with the "system" concept to any major extent,

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it should be realized that training is part of a total system.

The interrelationship between personnel selection and training becomes apparent when one considers training performance as a possible criterion of selection. Psychological tests have been used to attempt to forecast training success among nurses (18) and to predict performance in a college supervisory training course (17). It would seem that psychological test performance, found significantly related to training success, might be correlated with other selection criteria as well. On the other hand, tests which forecast other criteria of attendant success such as tenure; e.g. (2, 4), seem worthwhile to investigate as predictors of success in training programs.

McGehee and Thayer (15) present a systematic overview of the training problem. Their book provides a basic framework for thinking about training problems and should prove valuable for both training directors and researchers. Their basic viewpoint appears to be closely related to the "systems" view previously described. Although the book is oriented toward the industrial organization, it is also quite applicable to the mental hospital and other types of organizations. McGehee and Thayer stress the notion that training is a tool of management—just as is selection or cost accounting—rather than a field or entity in itself.

The purpose of this paper is to present a basic overview of the problems and issues in attendant training. The organization is, in part, consistent with certain training dimensions reviewed by McGehee and Thayer. Training issues included apply not only to attendant training but to general training problems as well. Efforts will be made to discuss the following basic training issues:

1. Determining training needs
2. Learning principles and training
3. Methods and techniques in training
4. Evaluation of training effectiveness

DETERMINING TRAINING NEEDS

The first step in setting up any training program involves the determination of training needs. Glaser (10) considers the initial step to be one of stating specific training objectives in operational terms, which means that they should be spelled out in a behavioral manner requiring minimum interpretation. Thus, to state that the objective of attendant training is to produce good attendants would be a vastly inadequate objective. While literature is available on how attendant training programs are conducted, very few, if any, are concerned with efforts to analyze the training needs carefully and in a systematic manner. Although this first step seems obvious, it is frequently overlooked or performed in a casual manner.

McGehee and Thayer (15) present a basic framework or model for determining training needs. They describe a threefold approach which includes (a) organizational analysis, (b) operation analysis, and (c) man analysis.

In organization analysis, the primary concern is to discover the level in the organization where training emphasis should be placed. The aim is to determine what individuals must be trained for present and future organizational effectiveness.

Operations analysis is primarily concerned with the contents of the training program; i.e., "what" is to be taught. Emphasis is on the task and not the individual employee. The elements of an operations analysis includes the determination of (a) the standards of performance, (b) the tasks that constitute the job, (c) how each task

must be performed, and (d) what skills, knowledge, and attitudes are necessary.

In general, the techniques of operations analysis are much like those of conventional job analysis. Glaser (10) mentions a number of job analysis methods: direct observation, activity check lists, job questionnaires, job records, reports to the observer about completed jobs, and the sorting of descriptive task statements made by the observer. It is during operations analysis that the role of the attendant as conceived by the organization emerges.

In man analysis, focus centers on the individual training needs. Man analysis seeks to find out (a) if the employee needs training, and (b) the extent to which training is required. Man analysis may be considered in two steps: (a) summary man analysis and (b) diagnostic man analysis. Summary man analysis is concerned with how well the employee performs his job in a general manner; i.e., how well does he carry out his assigned tasks. Diagnostic man analysis involves determining the specific quality of the individual's job behavior and how his behavior must be altered to meet the requirements of the job.

In summary, McGehee and Thayer provide a useful framework for analyzing training needs. In the process of developing a training program, however, it should be realized that a number of other areas must also be studied. Questions must be answered such as: (a) what learning principles can be used in the training process, (b) what methods and techniques can be employed, and (c) how can the total program and specific aspects of the program be evaluated?

LEARNING PRINCIPLES AND TRAINING
Wolfe (25) refers to the psychology of training as "the applied psychology of learning."

McGehee and Thayer (15) consider learning to be the central process in training. Despite the importance of learning in the training process, very little concern has been devoted to it in the hospital training literature. McGehee and Thayer point out that basic learning research in industry is also lacking. Thus, in the area of attendant training, it seems that the basic concern should be both to utilize existing learning principle and to test the various learning principles for specific situations.

There are probably many limitations to our existing knowledge in learning. As McGehee and Thayer have indicated, most of the research is done in university settings with animals and students as subjects or in military situations where the subjects are military personnel. How much generalization can be made from such research is difficult to determine. In any case, many of the existing principles, despite their limitations, seem to be "better guides to planning industrial training than the folklore of training" (15, p. 131).

Learning principles and their application to training programs have been described by a number of authors; e.g. (10, 14, 15, 21, 25). Two principles of recognized importance in learning (feedback and reinforcement) are briefly described here to illustrate their adaptation to training programs. Other principles which merit consideration in planning a training program include repetition, habit interference, knowledge of principles, motivation, distribution of practice and training sequence.

1. *Feedback*

This is frequently referred to as knowledge of performance or knowledge of results. As Mosel (16) has indicated, it is perhaps one of the best validated principles

ples of learning. "The trainee not only must attempt to make the response which the trainer teaches, but he must also know how well he has succeeded in doing this" (16, p. 173).

Mosel reports that feedback influences learning in two ways: (a) the trainee obtains information on what should be learned, and (b) it increases motivation to learn. Existing evidence further suggests that the feedback given should be relevant (not redundant) and specific. "The more specific the knowledge of performance, the more rapid the improvement and the higher the level of performance" (16, p. 177). In addition, feedback should be immediate; i.e., the longer the delay, the less effective it is in influencing learning. Thus, any training program should find it profitable to utilize feedback principles.

2. Reinforcement

In brief, reinforcement in the training situation may be thought of as reward given for the performance of a task in an acceptable manner. Such rewards can take the form of progress reports, recognition, verbal approval, etc. The reinforcement given may be positive; i.e., reward may be given for the performance of a correct response, or it may be negative; i.e., a trainee could be removed from an undesirable job to one more desirable by performing a response correctly. Reinforcement may be given immediately or it can be delayed, but immediate reinforcement is generally considered more effective. Thus, a training program could probably be made more effective if reinforcement principles are carefully studied and properly applied.

METHODS AND TECHNIQUES IN TRAINING

In planning a training program, it is necessary to give careful consideration to the

teaching methods and techniques to be employed. McGehee and Thayer (15) describe a number of methods and techniques, which differ largely in the amount of instruction received on and off the job. Four methods discussed include (a) on-the-job training, (b) vestibule training, (c) integrated on-and off-the-job training, and (d) formal off-the-job training. Attendant training programs are probably largely planned along the lines of (c), incorporating both classroom or laboratory training and performance on the job. The success of such a program seems largely dependent on the quality of integration between the classroom activity and the job. McGehee and Thayer also discuss specific techniques of training, such as lectures, conferences, case study, role-playing and sensitivity training.

Research cited by Quay (19) indicates that lectures and group discussions are among the more widely used methods in attendant training. However, there is recent evidence of increased emphasis on the group discussion approaches. Harris and Johnson (11) report the use of weekly group meetings aimed toward developing the therapeutic potential of the aide. They describe a two-year program developed in a psychiatric section of a general hospital. "The purpose of the program is to provide a therapeutic environment for the patients which is focused around interaction with one another and with all staff members" (11, p. 26).

Johnson and Whitney (12) describe an informal six-week course that consists of two one-hour group discussions per week as part of an inservice education program. They point out that one aim was to assist the aides in applying psychiatric nursing principles to improve their understanding and observation of patient behavior. Wax (24) utilizes the discussion technique to

teach attendant supervisors the techniques of counseling employees.

Gertz (9) has studied human relations training with interdisciplinary groups in a mental hospital. The laboratory or sensitivity training approach was employed using four exit teams of a state hospital with consultants conducting the training. The team members remained in their family work group, but the program was conducted a substantial distance from the hospital. Gertz described in detail the training process and attempted to evaluate the effectiveness of the training program. He reported that no conclusive evidence was available to demonstrate that such programs will result in substantial change in organization problems and interpersonal conflicts.

In addition to the methods and techniques already mentioned, there are several special techniques which seem worthwhile for trainers to consider in planning a training program. These include the use of films, training devices and simulators, automated teaching, and business games. Although films have many of the shortcomings of lectures, one advantage is that usually a highly skilled instructor is used. One disadvantage is the reduction in opportunity for trainer-trainee interaction. If used wisely, it can be of significant value in a training program. Johnson and Whitney (12) use films in their psychiatric aide training program.

Before ending the discussion of methods and techniques, it might be noted that a great deal of research is needed to assess the effectiveness of these various approaches. There is a real shortage of data available on assessing specific methods and techniques used in attendant training. Evidence of limited data and some of the problems in attendant training is reported by Quay (19).

In addition to the specific techniques, such factors as length of training, intelligence and other variables need to be investigated. Length of training and its effect on an undergraduate trainee group in human relations training was studied by Maier, Hoffman, and Lansky (13). They report that the typical human relations course is of insufficient length to change behavior significantly. Thus, length of the training period seems to be a variable worth further study in the hospital environment.

Cline, Beals, and Seidman (5) investigate length of training and intelligence in a military basic training situation. They report that high IQ groups perform significantly better on cognitive tasks in an accelerated four-week program than normals in both an eight-week program and an accelerated program.

However, they state that accelerated groups performed at an inferior rate on rifle marksmanship and physical fitness. Thus, it seems that the factor of intelligence merits careful study in attendant training programs as well as length of training. It may be possible that accelerated programs for brighter attendants could accomplish as much, if not more, than longer programs for less bright attendants.

EVALUATION OF TRAINING EFFECTIVENESS

The paucity of research evidence to demonstrate training effectiveness with attendant employees is clearly demonstrated by Quay (19). As Quay has pointed out, the enormous expense in both time and money required for training makes the need for evaluation a very practical one. In many cases, training is assumed to be good and many people are content to verbalize success based on casual observation.

There appears to be two major problem

areas in assessing the impact of training. One is the type of research design employed to assess training and the other concerns the measures of criteria. An attempt will be made first to examine the possible research designs that might be used.

Research Designs

McGehee and Thayer (15) describe four possible basic designs that can be employed in training. The first design is referred to as "after training, without a control group," where measures are taken only at the end of the training program. This is reported to be the most frequently used and the most naive type of design. It fails to assess behavior change and, without a control group, it cannot be compared with the effects of "no training."

The "before and after, without a control group" is the second design, which basically involves taking measures both before and after the training period. This procedure affords the opportunity to assess behavior change, but has limitations because of the absence of a control group. A number of studies employ this design and it does seem to contribute substantially to knowledge about training effectiveness. There are cases in organizations, of course, where control groups may not be possible because of administrative reasons. Yet, one must realize the potential existence of the "Hawthorne effect" in such designs.

The "after training, with a control group" design, where measures are used only at the end of a program, does not reveal behavior change, but the control group does offer advantages. An example of its value can be demonstrated with the use of ratings, particularly in the case of orientation and indoctrination training. Having attendant supervisors to rate newly hired employees before training may not

be very meaningful. However, by the end of a training period, supervisors would have sufficient information that would enable them to rate their performance accurately. Comparison of the training group with a control group would give indication of training effectiveness.

The "before and after, with a control group" appears to be more efficient than the previous designs mentioned. In this situation, of course, measures are not only taken before and after training with the training group, but also before and after with a "no training" group. Training research using such a design would probably yield more training information than the others, all other things being equal.

In the four basic designs described, there appears to be one basic factor not considered, and this concerns the issue of temporary versus permanent or long-range training effectiveness. Research at the International Harvester Company (8) assessing a two-week human relations training program with foremen revealed that the foremen changed in performance on a leadership opinion questionnaire by earning significantly higher "consideration" and significantly lower "initiating structure" scores at the end of training than at the beginning. However, follow-up after the foremen returned to their jobs shows that the change was not permanent. This suggests that concern should not only be placed on the immediate effects of training, but also on the more permanent or lasting effects.

Quay (19) makes comments about the need for the long-term assessment in attendant training programs. Thus, if one wants to add the long-range dimension to the basic designs previously described, a total of eight training research designs would be possible. In other words, four additional designs would be added to the original

four, with an added long-range assessment.

The position taken in this paper is that most of the designs mentioned will contribute to our knowledge about the effectiveness of training, particularly since so much is needed in the area of training research. Of course, the "after design, without a control group" would perhaps have the most limited use as a design to assess training *per se*.

Training performance measures at the end of training could have value as a criterion against which to validate such personal selection devices as tests, application blanks and interviews. Similarly, after-training measures would be of value in comparing specific training techniques.

Criteria

Although the type of research design is a crucial issue to consider in the evaluation of training, a second problem needing serious consideration concerns the criteria of training success. Regardless of how efficient the research design might be, research effectiveness is highly dependent on the measure of success employed. In measurement, of course, reliability and validity must be given utmost consideration. Some methods of assessment include testimony, questionnaires, ratings, psychological tests and many others.

The most elementary and perhaps the least useful technique in evaluation is the verbal or written testimony of staff members and trainees. Harris and Johnson (1) use the testimony of staff to appraise their program of developing aides' potentials. Wax (24) reports that management and participants have responded enthusiastically to their program of teaching supervisors certain employee counseling techniques. Of course, both of these articles intend to describe programs rather than to

evaluate. Although such literature is useful, the more quantitative approaches seem destined to contribute more.

Questionnaires at the end of training are sometimes employed to evaluate training. Gertz (9) uses a post-evaluation questionnaire to assess the effects of sensitivity training with hospital personnel. Johnson and Whitney (12) present questionnaires at the end of training to determine attendant trainee reactions to the program. Both of these studies exhibit the basic problems of the "after training, without a control group" design.

Rating scales, of course, are one of the basic techniques frequently employed in evaluation and they offer a great deal of promise when devised properly. It is a basic necessity for rating scales to have substantial reliability and validity. A good example of a rather well-developed scale is the Aide Performance Evaluation Scale (APEV) reported by Ellsworth, *et al.* (7). The APEV recognizes several areas of attendant behavior: (a) attitude toward supervision, (b) high-level skills, (c) motivation, (d) empathy, and (e) total job performance. Such efforts as exhibited by the APEV product should add substantially to progress in training research. Shotwell, *et al.* (22), recognize a number of the problems in supervisory ratings with attendants. She points out the problems of disagreement between administrators, professionals, supervisors and psychiatric technicians on how the attendant's job should be performed.

Psychological tests do not appear to be widely used in assessing training effectiveness among attendant employees, but they have been used in nonhospital organizations. Personality, attitude, supervisory and devised situational tests appear to offer promise of making significant contributions to our limited knowledge of what happens to the trainee during and after training.

Bass (1) reports mood changes using repeated measurements with a mood check list during a management training laboratory. Such research in attendant training programs could be informative. Tannenbaum, *et al.* (23), employs the same basic design as Bass; i.e., "before and after, without a control group," to assess sensitivity training effects using the California Psychological Inventory.

In a review of the "How Supervise" test, Rosen (20) mentions a number of studies indicating a positive relationship between the "How Supervise" and supervisor's performance. Rosen also demonstrated ways the "How Supervise" can be employed to assess supervisory training programs. Such tests as those reported, and others, could be of service in hospital training programs.

There are a number of other possible measures which might be considered in training evaluation. Perhaps the most widely used is the devised achievement test aimed toward assessing content learned in training courses. Such tests appear useful. Objective records may be worth considering as measurement tools, such as absence rates, tardiness, grievances and complaints, accident rates, turnover, disciplinary reports and others. Training diaries kept by trainees regarding their opinion and experiences during programs, as mentioned by Tannenbaum *et al.* (23), may be informative if analyzed for content.

As mentioned previously, criteria are very important in training research and must be given utmost consideration. It would certainly seem wise to use several measures rather than one in evaluating programs when these measures are available. The combining of several criteria using weighting procedures into a single one might also be quite valuable.

SUMMARY

In this paper an attempt was made to present an overview of some of the basic issues and problems in attendant training. Of course, most of the things that have been said can also be applied to training in general. Although the problems and issues in training are complex, effort was made to discuss four major aspects: (a) determining training needs, (b) learning principles and training, (c) methods and techniques in training and (d) evaluation of training effectiveness.

One of the first steps in developing a training program is to determine the training needs. This can be assisted by such approaches as organizational analysis, operations analysis, and man analysis. In the training process itself, it is necessary to think about how principles of learning can be most effectively applied, keeping in mind that the principles need further testing in the training situation.

Careful consideration must also be given to the methods and techniques to be employed in training, so that they can be utilized most efficiently. Again, it must be realized that the methods and techniques need research efforts to determine the relative effectiveness of each.

Finally, when planning a training program one must not forget that the effectiveness of the total training program needs to be evaluated. In assessing the training impact, a careful study of the research design and the criteria of measures of performance must be made. Although the major administrative problems in training have been largely omitted from this paper, it does not mean that they are unimportant. Such problems as who is to be responsible for the planning, organization, and execution of the program must be carefully studied and decided.

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A note on Tolor's "The personality need structure of psychiatric attendants"

In connection with another study in progress (4), a group of 30 male and 42 female psychiatric aides were given the Edwards Personal Preference Schedule (EPPS), which yields scores on 15 personality needs. These aides were chosen because they were familiar to building physicians. They tended to be slightly older (mean age 38.4), more highly educated (mean years of education 11.1), and employed for a longer period (mean years of employment 6.99) than is believed average for this institution.

Inasmuch as similar data had been reported by Tolor (6), it seemed useful to compare the two sets of findings.

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Table 1 summarizes the results of Tolor's investigation and the current one, as they compare to Edwards' normative group. Section A of the table lists for each sex the means and standard deviations of those EPPS needs on which both Tolor's Fairfield State Hospital and the current Norristown State Hospital groups differed significantly from the nationwide normative group. Section B of Table 1 lists those needs on which only the Fairfield sample differed from the normative population, and Section C lists those needs on which only the Norristown group differed.

As can be noted, the agreement between the two studies is impressive. In both Fairfield and Norristown, male aides saw themselves as less independent (Autonomy) and more inclined to be aware of the covert needs of themselves and others (Intracception). Female aides considered themselves more compliant (Deference), more aware of covert psychological processes (Intraccep-

TABLE 1

Edwards personal preference schedule needs showing differences between normative group and two psychiatric aide samples

	Male			Female		
	Norristown		Normative	Norristown		Normative
	Fairfield Mean	S.D.	Mean	Fairfield Mean	S.D.	Mean
<i>A. Both Fairfield and Norristown Samples Differ</i>						
<i>Need</i>						
Autonomy	10.85	3.95	12.10	4.60	14.02	4.38
Intracception	16.61	4.70	16.50	4.79	14.18	4.42
Deference	16.40	2.60	15.98	3.59	14.72	3.84
Autonomy	10.63	3.80	10.38	3.65	12.10	4.11
Affiliation	14.25	3.84	14.31	3.65	17.76	4.15
Intracception	17.70	3.65	17.14	4.21	15.28	4.13
Dominance	11.50	4.15	13.52	4.45	10.24	4.73
Endurance	18.23	4.15	17.93	3.89	16.50	4.66
<i>B. Only Fairfield Sample Differs</i>						
Endurance	18.39	4.83	17.73	5.05	16.97	4.90
Succorance	11.85	3.18	12.17	4.60	12.86	4.55
Heterosexuality	6.75	4.55	8.43	5.55	8.12	6.59
<i>C. Only Norristown Sample Differs</i>						
Nurturance	17.78	3.00	16.24	4.20	18.48	4.43
Change	15.55	4.23	13.40	4.06	15.99	4.73
Aggression	10.60	4.21	12.76	3.29	10.16	4.97

tion), more persistent in life style (Endurance), and higher in executive needs (Dominance) than did the normative group. Female aides were less independent (Autonomy) and less socially outgoing (Affiliation) than women in general.

The higher scores of Fairfield male aides in Endurance and the lower scores of female aides in receiving assistance from others (Succorance) and Heterosexuality were not repeated in the Norristown sample. Conversely, the Norristown female aides saw themselves as less anxious to give assistance to others (Nurturance), less in need of novelty (Change), and more Aggressive than the normative group, while these differences were not seen in the Fairfield group.

Thus, one of the requirements for acceptance of the idea that aides possess a different pattern of needs from other groups is established: the findings of one study are reproducible in a sample from another comparable group.

An even more important requirement for this acceptance, however, is a demonstration that the difference in need pattern is attributable to the subjects' status as psychiatric aides. Plainly, this has not been accomplished either by Tolor or by the present author. In addition to their differences in occupation, the subjects may differ from the general population used in establishing EPPS norms in age, education, geographic residence, socioeconomic status, racial or national composition, marital status, etc.—all variables which can be associated with behavioral traits.

Caution in asserting that "aides are characterized by this pattern" is provided by the literature from two sources.

First, it has been very difficult to establish the existence of reliable personality differences between attendants judged to be good or poor (1, 2, 4, 5). In this situ-

ation, matching on some social and demographic variables is achieved simply by having chosen two or more groups who work as attendants. This very close matching reduces the likelihood of spurious differences arising. If aides were as markedly different from the general population as these two samples suggest, one would expect the good aides to be sorted out from the poor aides a little more easily on the basis of personality measures.

An even more important source of caution is evidence from Koponen (3) of the wide range of differences in individual EPPS scores which he found associated with age, education, geographic region, income and rural vs. urban residence. For example, he found significant differences at the .001 level among four different age groups in 13 of the 15 EPPS needs. Evidence is thus ample that two groups cannot be said to differ unless they are matched on these important background characteristics.

On the other hand, Koponen lists among his conclusions that lower income and lower educational groups tend to be higher on Nurturance, Succorance, Affiliation, Deference and Abasement. If the present aide groups be considered somewhat below the mean in income and educational achievement, it is clear that they do not conform to this pattern. Neither Fairfield nor Norristown aides differ from the general population in Abasement. For both Nurturance and Succorance one of the aide groups scores in a direction opposite from what one would expect, and for Affiliation, both aide groups are lower instead of higher than the population mean. The higher Deference scores are the only ones in the same direction that might be predicted from Koponen's data.

Accordingly, one thus has a slight bit of evidence that the recurrent deviations

of aide need scores on the EPPS from the population means may not be solely a function of standard social or demographic differences between the aide and the general population. However, a real test of this hypothesis will not be forthcoming until a group of subjects from a similar social background who are in a different type of work have been used as controls.

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Functions of the state mental hospital as a social institution

Bitter denunciation of critics has tended to obscure careful inquiry into the nature of the socially defined functions of the state mental hospital (3). It is the contention of the author that the primary social functions of the state mental hospital are not the same as the publicly proclaimed purposes and goals of these institutions.

In contrast to rhetorical, often vague statements as to the functions of an institution, the primary social functions of the institution will tend to be defined by the nature of the power and authority delegated to that institution by society.

"Primary" functions will be *demand*ed of the institution by society. Power and authority will be made available to the institution for execution of these functions.

"Secondary" functions are characterized

by *hope*. Society hopes that the institution can serve certain functions with whatever resources can be made available. However, secondary functions are expandable. Sufficient power and authority to carry out secondary functions is not consistently made available.

Primary functions demanded of the state mental hospital have included (A) public safety and the removal from society of individuals exhibiting certain kinds of socially disruptive behavior (10); (B) custodial care for persons who, by reason of mental disorder, cannot care for themselves or be cared for elsewhere; (8). These primary functions have not really changed over the past 100 years; "change" has occurred chiefly with regard to our lack of candor concerning them.

Treatment and rehabilitation of the mentally ill has always been, at best, a secondary function of the state mental hospital. For many years it was not con-

sidered part of the function of the state hospital at all (6). Today treatment and rehabilitation are usually officially regarded as the primary functions of the state mental hospital, leading to a remarkable amount of self-deception and confusion on the part of society and the personnel working in these hospitals.

Professional personnel often naively believe that treatment and rehabilitation constitute the primary functions of the state mental hospital—a belief which is fostered by the use of the term “hospital” to refer to these institutions.

Consequently, competent professional personnel who are treatment-oriented tend to expend much of their energy attempting to obtain the necessary resources to carry out programs which are of only secondary importance to the hospital. Treatment programs are regarded as desirable but too expensive. Professional personnel who remain in state hospital systems tend to become part of the system, essentially accepting the reality of the primary, custodial care function of the hospital, frequently without acknowledging this to themselves, and certainly not to society. Becoming part of a system which does not openly acknowledge its primary functions may lead to a defensive denial of the true state of affairs, or to an endless, frustrating struggle to change the socially defined functions of the hospital; for example, by elevating the functions of secondary importance to the level of primary importance.

Without a change in the socially defined functions of the state mental hospital, relatively few patients in these hospitals can benefit from modern concepts of treatment (6). “The pressure for security is constant, unremitting, and a long accumulation of responses to this pressure for safe custody is embodied in hospital cus-

toms, traditions, regulations, laws, and architecture” (8). As long as treatment functions are of secondary importance, the power and responsibility delegated for the protection of society will tend to cripple treatment programs (8).

Historically, insane asylums were based not only upon the idea of restraint and punishment, with roots in the penal system, but also upon the medical model of care and treatment of the sick (9). The superintendent could assume medical responsibility for treatment, with the goal of enabling the patient to resume his place in society. The role of the warden, or the benevolent despot, was also assumed, with the superintendent exerting authoritarian control over his patients and staff, and a custodial care, public safety responsibility toward society. With little objection from the medical profession, treatment functions became less important as state governments assumed responsibility for operating insane asylums. The primary function of the insane asylum was to serve as a jail and poor-house for mentally disturbed individuals. At the same time, superintendents of these institutions became increasingly pessimistic about the possibility of treating the mentally ill, thus further facilitating the development of the insane asylum as a custodial care institution (6, 9). The superintendent rapidly lost the power to make decisions concerning psychiatric treatment for his patients. With a philosophy of custodial care for the rejected and “morally unfit,” living conditions in the insane asylums sank to the level of animal existence (2). The good superintendent was one who could operate at the lowest possible per diem cost which would enable human beings to survive physically.

Reform movements were ostensibly concerned with providing better treatment for the institutionalized psychiatric patient but

were actually forced to concentrate upon providing more humane custodial care—essentially higher quality poor houses which provided adequate nutrition, better sanitation and a bed. These reform movements met with only limited success until after World War II, following exposures of “snake pit” levels of custodial care (2).

Since World War II, gross abuse of patients has been largely, although not entirely eliminated. But except for the Topeka State Hospital in Kansas and a few other institutions, there has been relatively little increase in the psychiatric treatment powers of the state hospital superintendent.

State governments rarely exert the cruder forms of direct political interference with the operation of the state hospital today (such as using the position of superintendent as a political patronage job); and there is no direct interference with therapy. But the crucial powers which can make treatment programs possible are not consistently delegated by controlling legislative and administrative bodies.

For example, the state hospital psychiatrist will not be told that he cannot see his patients for individual psychotherapy. However, the question becomes an academic one when the psychiatrist is responsible for the custodial care of several hundred patients. It may not even be possible to plan a program of milieu therapy tailored to the needs of the individual patient (4). Under the circumstances, the physician responsible for care of so many mentally ill patients will probably not even be a qualified psychiatrist.

The legislature may even agree that special facilities are needed for the treatment of children and adolescents, and the superintendent may be encouraged to provide treatment programs for mentally ill youngsters—as long as he does not request

money for additional personnel and a school.

The superintendent may be free to select his professional staff—within limits which will make it almost impossible for him to obtain the services of qualified personnel. Authority to carry out psychiatrically indicated treatment becomes meaningless under such conditions.

However, the superintendent does have more than adequate power and authority to carry out the custodial care functions of the state hospital. This consists chiefly of the power to control and limit freedom of movement and action for the staff as well as for the patients (10). The superintendent who fits most comfortably into this system will need to be an efficient manager and warden. He will be acutely aware of and responsive to his primary custodial care responsibilities. He will be concerned about appearances and will worry most about the patient who might give the hospital a bad name. Treatment programs will be tolerated as long as they do not interfere with the custodial tranquility of the hospital. Measures which enable the hospital to operate more quietly and efficiently are likely to be regarded with favor.

In many respects (use of physical restraints, breakage, cost of maximum security facilities), tranquilizing drugs reduce the cost of custodial care, and they have become popular with state legislatures, inasmuch as the cost of such drugs has not been higher than the cost of caring for disturbed, destructive patients.

As far as the superintendent is concerned, he will rarely have to worry about losing his job if he carries out the custodial care functions of the state hospital with a minimum of disturbance to the community. There is merely the public relations task of paying lip service to the secondary functions of the state hospital

by uttering comfortable generalities about treatment. Fortunately, there are some aggressive superintendents who do not adjust peacefully to this system. But they are in the minority.

It must not be supposed that police power is necessarily incompatible with the power to treat patients in a mental hospital, as Szasz contends (10). But the use of such power ought to be clearly defined and limited to physical restraint and control of those individuals who present a danger to themselves or to others by reason of mental illness. The adoption of voluntary admissions and the open hospital represent a hopeful trend toward elimination of unnecessary and unwarranted extension of police power for the state mental hospital. Unfortunately, freedom from authoritarian control over professional personnel has made little progress. The physician in the state hospital is still treated as though he were an overpaid servant of the state.

The state hospital starts out with the premise that it must do what it can with the resources provided, and that costs are more important than are the treatment needs of the patients. Furthermore, these costs start from a baseline of minimal custodial care and any money appropriated above that level may be regarded by the legislature as an expendable luxury. This philosophy has strangled the treatment potential of the state hospital to such an extent that many professional people have come to believe that the state hospital is hopeless, and that it would not be able to provide good psychiatric treatment under any circumstances. Evidence to the contrary is simply ignored. The state hospital still gets the most difficult and challenging treatment problems, but it has few professional personnel who believe that something can be done about them (1, 7).

At the present time, efforts to utilize the

state hospital as a hospital are effectively checked not only by a custodial care financial base, but also by the substitution of coercive authority for medical authority. In order to be held responsible for treatment results, the psychiatrist and other professional personnel must have commensurate privileges and authority. Under the present system, the state hospital tends to attract physicians who are in an inferior position professionally—and who can therefore be exploited and subjected to unreasonable restrictions on their professional freedom.

The contrast between the working conditions and professional status of the psychiatrist in private practice or in an academic setting and the staff psychiatrist in the state hospital is so great that adequate financial remuneration alone has not enabled those state hospital systems which have tried it to retain well-qualified psychiatrists (5).

Thus, despite advances in the hospital care of the mentally ill, the socially determined rules under which the state mental hospital must operate have changed very little. Considering the custodial care system in which the state hospital operates, any progress in the treatment of the mentally ill in state hospitals is remarkable and is a tribute to the skill and devotion of those who are able to sustain treatment programs in the face of formidable odds. The superintendent who would support treatment programs in the state hospital must do so by attempting to utilize the powers of a manager and warden for the purpose of fulfilling the functions of a physician. In the older state hospital, chained to the custodial care tradition, the task is all but hopeless.

The state hospital can continue to exist primarily as a dumping ground for the treatment failures of other facilities, none

of which could function without a state hospital to take patients who cannot be treated elsewhere. However, for many patients the state hospital is the only resource available for the treatment of severe mental disorders. The mentally ill individual may face the bleak prospect of looking for treatment in a hospital structured primarily for custodial care.

Patients will not be convinced by words and slogans that a state mental hospital is really a hospital. Despite repeated assertions that the state hospital is a desirable place to go for the treatment of severe mental illness, most patients still dread these institutions. This state of affairs cannot be changed merely by calling an insane asylum a hospital, by better public relations, or by denouncing as selfish, professional personnel who refuse to work in state hospitals.

A more hopeful attitude toward the state hospital is associated only with solid evidence that the hospital is really there to treat sick people, and does not exist primarily as a place where people are "put away." Few competent professional personnel will work in the state hospital unless the hospital has a primary treatment as well as a custodial care reason for existence.

Even the best treatment program will not substitute for appropriate power and authority in the state hospital system. As long as the state hospital superintendent has the power and authority primarily of a warden, he can be held responsible only at the custodial level of patient care.

For the majority of state hospitals, a genuine shift in philosophy must precede a change from a primarily custodial care institution to a hospital. If our society is content to demand security and custodial care but merely hope for effective treatment, the state mental hospital is likely to remain primarily a custodial care institu-

tion (8). The search for well-qualified professional personnel could be abandoned.

However, if effective psychiatric treatment is also a primary function of the state hospital, financing and staffing must start from a consideration of the treatment needs of the patient—and this would require well-qualified professional personnel. If, as is likely, the hospital must serve both custodial care and treatment functions, a distinction must be made as to what constitutes a good treatment service and what constitutes a good custodial care service, with resources allocated accordingly.

Before it is assumed that agencies such as the general hospital, the community mental health center and the short-term, intensive treatment mental hospital can take over all of the present functions of the large state mental hospital, a closer look should be taken at the many needs currently met by the state mental hospitals.

For many patients, the constricted, simplified, structured environment of the state hospital is in itself sufficiently therapeutic to permit social improvement and recovery. Some patients require prolonged treatment in a structured environment. Other patients are sufficiently shocked by the dreary atmosphere of the back wards to pull themselves together. Patients who are unable to meet the demands of society often attain optimal adjustment in the state hospital. Unfortunately, the beneficial aspects of the state hospital are incidental effects of their custodial care functions.

The social functions which the state mental hospital serves cannot be wished away. But perhaps professional personnel in the mental health field can ask what the social functions of the state hospital ought to be. Is the state hospital the best resource for the custodial care of the brain-damaged geriatric patient? Is it really necessary to operate the state hospital

within such an authoritarian, prison-like structure? How many patients need to be hospitalized only on the basis of commitment?

Significant changes in the primary functions of the state mental hospital cannot be effected by public expressions of noble purpose when it is not made clear that there is a tremendous discrepancy between the actual operation of the state hospital and the professed hope for effective treatment.

SUMMARY

The primary functions of the state mental hospital are those demanded of the institution by society. These functions may be subsumed under the general heading of custodial care. In order to carry out the custodial care functions of the state hospital, the superintendent has the coercive power and authority of a prison warden, but he has relatively little power to carry out psychiatrically indicated treatment programs. Treatment and rehabilitation are publicly professed to be the primary functions of the state mental hospital, but in practice these functions are of only secondary importance.

Treatment is effectively limited by non-professional legislative and administrative restrictions through inadequate appropriations for treatment programs and by limiting the authority of the superintendent to control admissions to the hospital and to select qualified professional staff. The superintendent who attempts to run a treatment-oriented state hospital faces the almost impossible task of converting the coercive power of a warden to the medical power of a physician who can really determine psychiatric treatment programs.

Regardless of other factors—such as salary—qualified professional personnel

are reluctant to work in an institution which serves primarily a custodial care function and which also restricts their professional freedom. In order to make the state mental hospital a "hospital" in fact as well as in name, effective psychiatric treatment must be a primary, rather than a secondary function of the state mental hospital.

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Book Reviews

AND ALWAYS TOMORROW: One Family's Search In The Universal Problem World of Adolescent Mental Illness

By Sarah E. Lorenz

New York, Holt, Rinehart and Winston, Inc., 1963, 250 pp.

While I was reading *And Always Tomorrow* by Sarah E. Lorenz, two of my house guests kept sneaking it away from me or frankly demanding where I had put it, saying, "I just have to see what they do next" or "I have only a few more pages to the chapter."

This proved to be a good thing as it stirred up discussion and showed what strong appeal this book has. Writing under a nom de plume, the author relates the intimate, personal details of a family's tragedy. She writes beautifully, so that the edge is taken off the sorrow one feels in admiring this mother's courage, sensitivity and relentless determination to save her child at all cost.

The book is a pitiful description of the overwhelming difficulties all families must meet when confronted with the nebulous, bewildering horrors of adolescent mental illness. What makes matters worse is that these particular parents are most intelligent and flexible and harmonious in their relationships, far above the average in their willingness to sacrifice themselves in hopes of a cure for their boy.

At one point the father gets a leave of absence from his job, they rent their house, mortgage their possessions, farm out their younger son and go to live for a whole year in a hospital to be part of a research project. This proves to be a disaster, as the researchers are more interested in proving an hypothesis than in relieving the pain of the family and the sickness of the son.

At long last they give up and put Kenneth

in the state hospital, the one thing they had been desperately trying to avoid. Although the book offers no solutions, it ends on a note of hope, showing how state hospital care had improved during the course of Kenneth's illness. At first the hospital was purely a custodial institution. At the end, Kenneth, though not cured, is coming home regularly, still an active participant in the family life.

Reading *And Always Tomorrow* makes those working in the mental health field want to renew their efforts. It makes one proud to be part of the army of doctors, nurses, social workers, laboratory technicians and parents determined to find the cause and successful treatment of this most horrible scourge.—MRS. GODFREY S. ROCKEFELLER, Greenwich, Conn.

PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE

By George L. Engel, M.D.

Philadelphia, W. B. Saunders Co., 1962, 435 pp.

This is a good book for serious students. Although it is clearly written it is not easy to read because the author deals with complex issues by summarization and condensation more than by explication or simplification.

As he says himself in his excellent introduction, this is a book which must be studied over and over again with the help of a teacher, as a student increases in experience. I agree with the author that anyone who does so will find added depths in the theoretical exposition with each new reading.

Every chapter includes a carefully chosen list of references to the researches, the findings of which underly the test. The book

contains no clinical examples because the author expects these to be supplied by the teacher. It is of interest that in his introductory remarks the author addresses the teacher more often than the students, and although the book is written primarily for medical students, its level of exposition makes no intellectual concessions and is likely to stimulate serious thinking and evoke fresh ideas also among their professors.

The book mirrors the personal interests of its author and is rather variable in its coverage of different topics. It devotes major consideration to an exposition of psychoanalytic psychology in line with the writings of Rapaport. It emphasizes the biological bases of psychological processes and devotes special attention to the theory of drives and to varieties of affect. It deals particularly well with the biopsychological development of the young child and emphasizes the importance of maternal handling, but pays scanty attention to transactions in the family (10 pages in all), which are mainly devoted to a brief summary of

some of the work of Spiegel and Kluckhohn.

The influence of social and cultural factors is mentioned only briefly. The psychological development of adults is also skimmed over. The psychology of pregnancy and old age are dealt with inadequately. The concept of exogenous and endogenous stress is rather fully discussed, and its harmful effects in conjunction with other etiological factors are examined. The book ends with a brief survey of psychopathology and of the varieties of psychiatric disorders, particularly those which are likely to be encountered in a general hospital.

I can certainly recommend this as one of the key books to be read both by students of medicine and psychiatry and by their teachers. It deals well with those important areas in which its author has a special interest. The author leaves it to the professor to direct the attention of his students to other areas, and to bring the theoretical concepts to life by his clinical teaching.—
GERALD CAPLAN, M.D., Harvard University
School of Public Health, Boston, Mass.

Notes and Comments

ROBERT H. FELIX, M.D., RETIRES AS DIRECTOR OF NIMH

Robert H. Felix, M.D., who has served as director of the National Institute of Mental Health since its establishment in 1949, retired from government service effective October 1. He has accepted an appointment as dean of the School of Medicine, St. Louis University, St. Louis, Mo.

In commenting on Dr. Felix's retirement, Luther L. Terry, M.D., Surgeon General of the Public Health Service, stated: "The entire program of the NIMH reflects his foresight, administrative skills, professional knowledge and his ability to articulate its technical, scientific and humanitarian needs and achievements."

He added: "Dr. Felix has been an extraordinarily effective leader in the development of a new national mental health program based on knowledge, common sense and concern for human dignity. His qualities of leadership and persuasion have helped to rally thousands of professional persons and interested citizens to his belief that the mentally ill can best be served by a community-based program of treatment providing a continuity of care, available to everyone at the time of need."

As chief of the Division of Mental Hygiene of the Bureau of Medical Services, the predecessor of the NIMH, Dr. Felix helped to develop the National Mental Health Act of 1946 and to prepare the groundwork for the national mental health program he has administered since 1949.

In addition to his service as director of NIMH, Dr. Felix has participated in countless other professional and civic affairs.

He is also a past president of the American Psychiatric Association.

He has been the recipient of many honors in the professional and academic world.

He was awarded the Salmon Medal in 1963 by the New York Academy of Medicine for his distinguished contributions to psychiatry. He has also received the Nolan D. C. Lewis Award, the 1963 Edward A. Strecker Medal and the 1961 Rockefeller Public Service Award. He received the National Conference of Social Welfare Award for outstanding contribution to the social welfare in 1964.

He holds honorary degrees as Doctor of Science from the University of Colorado, Boston University and the University of Rochester, and the degree of Doctor of Laws from the University of Chattanooga, Tenn., and Ripon, Wis., College.

As Assistant Surgeon General, he was commissioned in the Public Health Service in 1933. He then served as clinical director and executive officer of the PHS Hospital at Lexington, Ky., and as assistant chief of the Division of Hospitals of the Bureau of Medical Services.

During World War II he served first as psychiatrist and then as senior medical officer of the U. S. Coast Guard Academy at New London, Conn.

MENTAL HEALTH WEEK TO BE OBSERVED MAY 1-7 EACH YEAR

Beginning in 1965 the dates for Mental Health Week will be May 1-7 every year. Since its inception in 1949, Mental Health Week has been designated as that calendar week which included the first day of May.

The change was agreed upon by the National Association for Mental Health and the National Institute of Mental Health, the cosponsors of Mental Health Week.

CARE AND TREATMENT, NEW FACILITIES

One-third of the Veterans Administration's 115,000 hospitalized veterans, the normally

long-term mental patient classified as schizophrenic, can safely be returned to community life for considerable periods of time, oftentimes permanently, the VA reported recently.

The government agency based its findings on a five-year research program now nearing completion.

The study, involving 1,319 patients in 12 VA neuropsychiatric hospitals, indicates that expatients of this type contribute fewer acts of violence, fewer felonies and fewer alcoholic cases to the police blotters of their communities than the average male.

The schizophrenic normally represents 75 per cent of those veterans occupying VA neuropsychiatric beds. All types of mental patients represent roughly half of those receiving hospitalization in the VA's 168 hospitals.

Although nine out of ten of those included in the study were discharged during the five-year period, some 40 per cent required additional treatment within one year, and two-thirds required additional hospitalization within four years. Some have returned to full-time employment and to their families.

* * *

The new 710-bed Washington, D. C., Veterans Administration general medical and surgical hospital, scheduled to open early in 1965, will include facilities for 240 psychiatric patients. The psychiatric section will consist of eight 30-bed nursing units. Each unit will contain four single bedrooms, one room with two beds, and six rooms with four beds. Each unit will also have its own solarium, sitting room and dining room.

Similar sections are planned for other new VA general medical and surgical hospitals and, where existing general hospitals are closely affiliated with a nearby medical

school, comparable facilities will be established, with corresponding reductions in the number of obsolete beds in predominantly psychiatric hospitals.

* * *

The Edwin B. Elson Activities Therapy Building at Hillside Hospital in Glen Oaks, Queens, N. Y., was dedicated June 7, 1964. The new \$1.5 million center is expected to have a strong impact on treatment programs in psychiatric hospitals. It brings together under one roof a diversity of social, recreational, occupational and educational facilities for 200 patients. Soon it will also house a day hospital. It is the ninth building on the Hillside grounds.

The center was named for Edwin B. Elson, a former Hillside trustee who left a substantial sum toward its construction. The building was a joint project of the hospital and of the City of Life Building Fund of the Federation of Jewish Philanthropies of New York.

TRAINING

During the week of July 6-10 the New York University School of Education conducted an Invitation Workshop in Curriculum for 20 experienced teachers of emotionally disturbed children. Teachers attending represented a variety of public and private school programs serving children with a broad spectrum of emotional and learning disabilities. The program was subsidized by the New York State Department of Mental Hygiene and conducted by Professors Evelyn D. Adlerblum, Frances Minor and Chandler Montgomery.

LEGISLATION

The White House has assured the National Association for Mental Health that the Administration plans to renew its efforts to restore the initial operations provision

of the Community Mental Health Centers Act of 1963 (Public Law 88-164).

A letter pledging the President's continued support of this measure came in response to a letter NAMH president Frank E. Proctor had sent to President Johnson urging that he "propose initiation of legislation which would provide for federal aid to the states for the initial operations of the community mental health centers to be constructed under Public Law 88-164."

The NAMH has received similar letters pledging support for the initial operations provision from Congressman John E. Fogarty of Rhode Island, a member of the House Appropriations Committee, and from Senator Lister Hill of Alabama, chairman of the U. S. Senate Committee on Labor and Public Welfare.

* * *

Requests made by the National Association for Mental Health and other interested organizations resulted in the inclusion of planks on mental illness in both the Republican and Democratic Platforms for 1964. The Republican Platform was adopted by the Republican National Convention in San Francisco July 14. The Democratic Platform was adopted by the Democratic National Convention in Atlantic City August 25.

In Section Three, titled, "Faith in the Individual," the Republican Platform calls for "continued federal support for a sound research program aimed at both the prevention and cure of disease and intensified efforts to secure prompt and effective application of the results of research. This will include emphasis on mental illness, drug addiction, alcoholism, cancer, heart disease and other diseases of increasing incidence."

The Republican platform also pledges "vocational rehabilitation through cooper-

ation between government—federal and state—and industry, for the mentally and physically handicapped, the chronically unemployed and the poverty-stricken."

In a section titled "The Individual" the Democratic Platform states: "We will continue to fight until we have . . . insured adequate assistance to those elderly people suffering from mental illness and mental retardation."

"We will go forward with research into the causes and cures of diseases, accidents, mental illness and mental retardation."

And in the section titled "Democracy of Opportunity," the Democratic Platform pledges: "We will . . . help the physically handicapped and mentally disadvantaged develop to the full limit of their capabilities."

An NAMH representative had testified before the Committee on Resolutions and Platform of the 1964 Democratic National Convention in Washington, D. C., August 17.

Early in June Judge Jerome Robinson, chairman of the NAMH Advisory Council on Legislation and Public Policy, submitted to the Republican and Democratic National Committees an NAMH proposal for a mental health plank in their party platforms.

Judge Robinson suggested that the two National Committees consider the following points to be included in such a plank:

1. The need for continued and expanded federal aid for the development of community mental health services, including the initial staffing of community mental health centers;

2. The need for an intensified effort to improve the care and treatment of patients in state mental hospitals to assure prompt and adequate treatment for all patients.

3. The need for greater development

of local and state resources to meet the growing need for community mental health services;

4. The need for continued and expanded federal assistance for research, and for training of professional mental health personnel.

5. The need for revision of state laws on the admission, retention and discharge of mental patients to assure the priority of medical considerations and the protection of the patient's constitutional rights.

6. The need for expanded coverage of psychiatric illnesses in health insurance plans, including hospital care, outpatient treatment and private treatment.

* * *

The Children's Bureau of the Welfare Administration, Department of Health, Education and Welfare, has approved seven comprehensive projects totaling \$4.6 million in federal funds to give new impetus to preventive maternity and infant care programs. In addition, state health departments are providing a minimum of 25 per cent of project costs to support the program.

The grants are the first awarded for this purpose under the Maternal Child Health and Mental Retardation Planning Amendments of 1963.

Goals of the projects include concentrated efforts to reduce the incidence of mental retardation caused by premature birth and complications associated with childbearing especially among low-income groups; to increase the number of prenatal clinics in neighborhoods where they will be more accessible to pregnant women; and to provide hospital care of good quality for women with complications of pregnancy and their infants.

* * *

The New York State legislature recently enacted legislation revising the state's laws

on admission, retention and discharge of mental patients.

According to state officials, this legislation achieves the following changes:

Encouragement of the increased use of voluntary and informal admission procedures;

Sharp reduction in use of judicial certification of involuntary patients. Admissions are initially medically-determined but are followed by notice and the opportunity for court review to safeguard the constitutional rights of patients;

Periodic court re-examination of the retention of involuntary patients; and

Establishment of a Mental Health Information Service, as arm of the judiciary, to gather information for the court and to advise patients and their relatives of their rights under the law.

AWARDS AND GRANTS

The Boston State Hospital, Boston, Mass.; The Dr. Norman W. Beatty Memorial Hospital, Westville, Ind., and the Fort Logan Mental Health Center, Denver, Colo., are this year's winners of the American Psychiatric Association's Mental Hospital Achievement Awards.

The announcement was made at the APA Mental Hospital Institute held in Dallas, Tex., September 28-October 1. "The Future of the Mental Hospital" was the theme of this sixteenth annual Institute.

The Gold Award was given to the Boston State Hospital for its Home Treatment Service Program.

The Silver Award was given to the Dr. Norman W. Beatty Memorial Hospital for its Teenage Activity Program.

The Bronze Award was presented to the Fort Logan Mental Health Center for its versatile program, making maximum use of part-time hospitalization.

A new federal grant of \$650,000 has been made to the Sidney Hillman Health Center in New York City to finance a four-year project for treatment of mental health problems of union workers. The object is to help workers under great mental strain to hold onto their jobs and to enable others to return to jobs which, because of unbearable mental problems, they have had to give up.

The Sidney Hillman Health Center is jointly sponsored by the New York Joint Board of the Amalgamated Clothing Workers of America, AFL-CIO, and the New York Clothing Manufacturers Association.

With the new funds provided, the Center will organize a mental health team of psychiatrists, social workers, psychologists and nurses who will work with a special committee composed of management and labor representatives.

* * *

The National Institute of Mental Health has made a grant to Professor Robert Root and the Syracuse University (N.Y.) School of Journalism to launch a pioneering program in mental health communications.

The award, which will total \$150,000 over the coming three years, will be used to support a training program, including fellowships and internships. Applicants will be prepared to become information specialists with state departments of mental hygiene and public relations workers in institutions and community psychiatric centers.

Applicants will be college graduates who have taken major work in journalism, English, sociology, psychology or similar fields. They will receive a master's degree at the end of the two-year program.

* * *

The Public Health Service has announced the award of \$390,000 for the first grants to states for planning comprehensive

action to combat mental retardation.

Each state is eligible to receive a maximum of \$30,000 in the first round of grant awards. The remainder of the appropriation of \$2.2 million will be available for supplementary grants to the states for mental retardation planning during the next fiscal year.

STUDIES, SURVEYS, REPORTS

Phenylketonuria, an inborn metabolic error which can lead to severe mental retardation, is not as rare as had been thought.

This is one of the major findings of a study released recently by the Children's Bureau of the Welfare Administration, Department of Health, Education and Welfare, which supported the study.

It shows that PKU occurred once in every 10,000 babies tested in a 29-state investigation during 1962-63. Previous estimates were that it occurred in one of every 20,000 births, and some scientists believed the incidence was as low as 1 in every 40,000 births.

The study, "Phenylketonuria, Detection in the Newborn as a Routine Hospital Procedure," was conducted in 505 hospitals and involved 400,000 newborn infants. The data were subsequently analyzed by Robert Guthrie, M.D., and Stewart Whitney of the State University of New York at Buffalo Medical School and Children's Hospital. The investigation detected 39 cases of phenylketonuria.

Single copies of the report can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C., for \$.30.

REHABILITATION

Federal agencies are going to be allowed, under special authority, to hire mentally

retarded persons without competitive Civil Service examinations.

Employment under this program will be limited to persons who are educable and who are certified by the appropriate state vocational rehabilitation agency as qualified physically, vocationally and socially to perform, in satisfactory fashion, the full duties of the position.

Representatives of the state rehabilitation agencies also will play an active role in helping the employees adjust to the job, and in advising and training those who will be supervising retarded workers for the first time.

Particular emphasis will be given to the program first in 14 metropolitan areas: Washington, D. C., Boston, Chicago, Dallas, Denver, Detroit, Hartford, Milwaukee, Newark, New Orleans, New York, Philadelphia, Seattle and San Francisco.

To encourage support for the program and fullest co-operation at the local level, awards will be given to the government agency doing the best job and to the community showing the best record or progress. The awards will be made in October, 1964, by the President's Committee on Employment of the Handicapped.

APPOINTMENTS

D. Ewen Cameron, M.D., president of the World Psychiatric Association since 1961 and chairman of the Department of Psychiatry at McGill University, Montreal, Can., has been appointed by the Veterans Administration to establish and direct laboratories in psychiatry and aging research at the Albany, N. Y., VA hospital.

The VA is vitally interested in information to improve treatment of aging veterans, many of whom are expected to have mental disabilities, and Dr. Cameron is

widely recognized as a leader in the two fields.

* * *

Phillip L. Sirotkin, Ph.D., has been appointed special assistant to the associate director for extramural programs of the National Institute of Mental Health. He will be responsible for evaluating the status and development of mental health services of local, state and regional organizations and the probable effects on states and local areas of the institute's extramural programs.

MEETINGS, CONFERENCES, SEMINARS

The development of the community mental health services and facilities provided for by the Community Mental Health Centers Act of 1963 and the development of state mental health planning programs will be the key reference points at sessions of the 14th Annual Meeting and Mental Health Assembly of the National Association for Mental Health.

The meeting will be held at the Hilton Hotel in San Francisco, November 18-21, 1964.

Assembly sessions will place parallel emphasis on care and treatment of the hospitalized mentally ill in existing state mental institutions. Other major program sessions will deal with the major program emphases of the NAMH, research, public relations and organization.

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The mid-winter meeting of the Academy of Psychoanalysis will be held in New York City on December 5 and 6, 1964. The theme is "The Role of Psychoanalysis in Community Mental Health Programs."

Leon Salzman, M.D., is the new president of the Academy. He is professor of clinical psychiatry at Georgetown Univer-

sity (Washington, D. C.) Medical School and a member of the Board of Directors of the Washington School of Psychiatry.

Other officers of the Academy for 1964-65 are: Judd Marmor, M.D., Beverly Hills, Calif., president-elect; Alfred H. Rifkin, M.D., New York City, secretary; and Earl G. Witenberg, M.D., New York City, treasurer.

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"Family Process and Psychopathology: Perspectives of the Clinician and Social Scientist" was the title of a conference held October 9-11, 1964, at the Eastern Pennsylvania Psychiatric Institute in Philadelphia.

It was sponsored by the Family Psychotherapy Project and its director, Ivan Boszormenyi-Nagy, M.D. More than 20 leading contributors discussed such questions as "Do families change in family psychotherapy?" and "How have recent changes in the community affected family patterns?"

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The ninth annual institute and the twenty-second annual conference of the American Group Psychotherapy Association will be held at the Jack Tar Hotel in San Francisco January 27-30, 1965. The theme of the Institute will be "The Formation and Conduct of Psychotherapy Groups in Various Existing Settings."

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The American Medical Association will hold its Second National Congress on Mental Illness and Health in Chicago November 5-7, 1964.

The Association's First National Congress on Mental Illness and Health was held in Chicago in October, 1962. At this meeting recommendations for a broadscale attack on mental illness were formulated by some 2,000 physicians, lawyers, clergy-

men, social workers and other professional and lay personnel. The First Congress, called by the AMA to implement the mental health program developed by its Council on Mental Health, was held with the cooperation of the American Psychiatric Association and the National Association for Mental Health.

PUBLICATIONS

The *Community Mental Health Journal* has been founded to facilitate communications among professionals in this field. The first issue of the interdisciplinary quarterly will appear early in 1965. It will contain articles on research and evaluation, program developments and theoretical issues.

A four-member board of editors has been appointed: Erich Lindemann, M.D., Lenin A. Baler, Ph.D., Saul Cooper, M.A., and Sheldon R. Roen, Ph.D., editor. Nationally known figures, representing a variety of disciplines and subspecialties, have agreed to serve as consulting editors.

Additional information may be obtained from the Managing Editor, *Community Mental Health Journal*, 12 Dimmock St., Quincy, Mass. 02169.

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The "article of the month" for the July, 1964, issue of *Rehabilitation Literature* was "The Vocational Rehabilitation of the Emotionally Handicapped in the Community" by Sol Richman. *Rehabilitation Literature* is published by the National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago, Ill. 60612

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The 1963 edition of the *Directory of Out-patient Psychiatric Clinics*, the only listing of its kind, has been published co-operatively by the National Association for Mental Health and the Biometrics Branch of

the National Institute of Mental Health. It includes data collected in 1963.

This latest directory includes psychiatric day-night services for the first time. The outpatient psychiatric clinics and day-night services are listed by location in states, territories and the District of Columbia. Information given on each facility includes name and address, clinic auspice, geographic area served, special groups served, clinic schedule and professional staff.

The directory also includes the following information for each state; department designated as the state mental health authority; department which operates the state mental hospital program; state hospitals for mental disease; public institutions for the mentally retarded; Veterans Administration hospitals for mental disease; state mental health associations.

The 1963 edition lists 1,700 clinics and 100 psychiatric day-night services; the 1961 directory listed 1,500 clinics; the 1962 edition contained 1,600 clinic listings.

The NAMH is distributing the 1963 directory at \$.70 per copy. There is a 25 per cent discount for purchases of 100 or more copies. Such quantity orders are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D. C. 20402.

A pamphlet intended primarily to guide the family physician in his management of the family with a seriously retarded child has been published by the Group for the Advancement of Psychiatry. Formulated by the Group's Committee on Mental Retardation, the 40-page report is titled "Mental Retardation: A Family Crisis—The Therapeutic Role of the Physician." Copies of the new pamphlet, GAP Report No. 56, may be obtained at \$.50 each from the Publications Office, Group for the Advancement of Psychiatry,

104 East 25th Street, New York, N. Y. 10010.

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Three significant conference reports have been issued by the Western Interstate Commission for Higher Education.

"Dialogues: Behavioral Science Research, Approaches to Selected Mental Health Programs" is a report on the seminars on behavioral science research held in institutions in the state of Colorado during the summer of 1963.

"A Clinical Approach to the Problems of Pastoral Care" is a report on two institutes on mental health held in Anchorage and in Fairbanks, Alaska, in September, 1963.

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"Mental Health Data Collection in the West" is the report of a conference held in Boise, Idaho, in August, 1963.

These publications will be made available upon request at no cost to professionals who desire copies for themselves or their organizations.

Copies may be obtained from: Staff Development Program, Western Interstate Commission for Higher Education, University of Colorado, Fleming Law Building, Boulder, Col. 80304.

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The Continuing Education Program of the University of California School of Public Health and the American Public Health Association have published "The Voluntary Health Agencies—Getting Community Action," Monograph Number 4. Price per copy is \$1.50, with quantity prices.

The publication may be obtained from the Western Regional Office, American Public Health Association, 693 Sutter Street, San Francisco 2, Calif.

An analysis of 11 community mental health centers, based on a comprehensive on-site survey of each facility, was published by the Joint Information Service of the American Psychiatric Association and the NAMH in late September.

The 240-page report, the first full-length publication ever released by the JIS, is titled "The Community Mental Health Center: An Analysis of Existing Models." The analysis was prepared in association with the Department of Mental Health of the American Medical Association and the Division of Community Psychiatry of Columbia University. Financial support for the on-site visits was provided by the National Institute of Mental Health, the Smith Kline and French Foundation, and the AMA.

The AMA has arranged to distribute a copy of the new report to each delegate attending the medical organization's Second Congress on Mental Illness and Health to be held in Chicago in November.

The 11 centers surveyed represent a wide variety of basic administrative models, including a state mental hospital, a public general hospital, a voluntary general hospital, a university teaching center, an independent mental health center, among others.

The new report includes an introduction by Walter E. Barton, M.D., medical director of the APA. The authors are Ray Glasscote, chief, Joint Information Service of the APA and the NAMH; David S. Sanders, M.D., M.P.H., assistant director, Division of Community Psychiatry, Columbia University; H. M. Forstenzer, M.D., assistant commissioner, New York State Department of Mental Hygiene; and A. R. Foley, M.D., assistant clinical professor of psychiatry, Columbia University.

* * *

A publication titled "Community Mental

Health Advances" has been issued by the National Institute of Mental Health. The new periodical, to be issued from time to time, will report innovations in state and local mental health programs and services.

The first issue includes articles on the Community Mental Health Centers Act, on new legislation in the states, on "crisis units," day hospitals, a calendar of events and a section titled "Current Reading."

Requests to be placed on the mailing list for "Community Mental Health Advances" should be addressed to the Publications and Reports Section, National Institute of Mental Health, Bethesda, Md., 20014.

FORM LIAISON GROUP ON MENTAL HEALTH

A Liaison Group on Mental Health has been formed as an exchange of information among national organizations concerned with the development of community mental health services.

The group is made up of representatives from the American Medical Association, American Psychiatric Association, National Association of State Mental Health Program Directors, National Association for Retarded Children, National Institute of Mental Health, and the National Association for Mental Health.

The liaison group held its first meeting in Washington, D. C., in November, 1963. At that time it was suggested that the group get together periodically to compare notes on what each member organization is doing in the area of community mental health services, to assure consistent information, guidance and encouragement from these organizations to their respective affiliates.

ARTICLES SCHEDULED FOR PUBLICATION IN FUTURE ISSUES OF MENTAL HYGIENE

- "Attitudes and Opinions of Clergymen about Mental Health and the Causes of Mental Illness" by Richard F. Larson.
- "Effect of Physician Training in Mental Health Principles on Mothers' Appraisal of Child Health Conference" by Marvin Belkins, Edward Suchman, Daniel Rosenblatt and Harold Jacobziner.
- "The Stigma of Mental Illness Can Be Erased" by Sister Loretta Maria.
- "A Study of the Use of Mental Health Media by the Lay Public" by Alexander C. Rosen and Frank F. Tallman.
- "The Integration of Community Psychiatry Training in a Traditional Psychiatric Residency" by Robert S. Daniels and Philip M. Margolis.
- "Specialization and Under-Utilization" by Mortimer Schiffer.
- "The Impact of Psychiatric Hospital Experience on the Community Adjustment of Patients" by David G. Berger, Charles E. Rice, Lee G. Sewall and Paul V. Lemkau.
- "Constructive Use of Psychiatric Consultation in a Rehabilitation Program" by Meyer S. Gunther, Clement Blakeslee and Ralph W. Susman.
- "The Role of the Psychiatrist in the Peace Corps" by Philip M. Margolis.
- "Mental Health Factors in an Indian Boarding School" by Thaddeus P. Krush and John Bjork.
- "Metastasis: A Social Psychological Concept Concerning Mental Health and Illness" by Martin Bloom.
- "Interviewing Techniques for Social Work Student Training" by George C. Alphine, Robert Chester, Nathan H. Kaufman, John K. Matsumuro and Murray K. Cunningham.
- "The Social Psychology of Prejudice" by Nathan W. Ackerman.
- "A Study of Children's Attitudes Toward the Cuban Crisis" by Bernice T. Eiduson.
- "A Skeptic's View of the Mental Illness Game" or "An Old State Hospital Hand's Jaundiced Look at Progress" by Walter B. Simon.
- "Personality Correlates of the Orientation of Mental Hospital Attendants" by Neil F. Thomas, Robert L. Houk and Herbert S. Ripley.
- "Studies of Medical Student Attitudes Toward Mental Illness" by Leonard F. Salzman and Robert H. Goldstein.
- "Expanding Comprehensiveness of Psychiatric Rehabilitation" by Laurence C. Hartlage.
- "Pupil Perception of Parental Attitudes Toward School" by Margaret Barron Luszki and Richard Schmuck.
- "Combating Post-Hospital Bends: Patterns of Success and Failure in a Psychiatric Halfway House" by Patricia Gumrukcu and Elaine Mikels.
- "Evil Self-Image: A Common Denominator in Learning Problems" by Mary A. Sarvis.
- "In Search for the Missing Link Between Social Changes and Social Work: A Canadian Experience in Action for Mental Health" by Anne Marie Orno.
- "Paid Employment as a Rehabilitative Technique in a State Mental Hospital" by Herbert J. Hoffman.
- "A Treatment Facility for College Dropouts" by Edgar A. Levenson and Martin Kohn.
- "Running a British Mental Hospital" by Bertram M. Mandelbrote.
- "Employment and Mental Illness" by Nyla J. Cole, Dixie Covey, Richard L. Kapsa and C. H. Hardin Branch.
- "Characteristics and Patterns of First Admissions with Schizophrenia Reactions to Ohio Public Mental Hospitals: 1958-1961" by Ben Z. Locke and Henrietta J. Duvall.
- "Recreation, Energy Level and Work of Schizophrenics" by William E. Morris, Hiram L. Gordon and David Rosenberg.

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